

Medicare Fee-for-Service Modifications and Medicaid Provisions of H.R. 1 as Enacted

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Summary

On November 22, the House of Representatives voted 220 to 215 to approve the conference report on H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Senate, on November 24, voted 54 to 44 to approve the conference report. Earlier, the conferees of the Medicare prescription drug and modernization legislation announced an agreement on November 16 and the legislative text was released November 20. The legislative language can be downloaded from the House Committee on Ways and Means website at: <http://waysandmeans.house.gov>. The bill was signed into law by the President on December 8, 2003.

As well as establishing a prescription drug benefit for Medicare beneficiaries, the legislation contains provisions that involving significant payment increases, payment reductions, an expansion of covered benefits, new demonstration projects and new beneficiary cost-sharing provisions for the traditional Medicare fee-for-service (FFS) program. The bill includes a measure that would require congressional consideration of legislation if general revenue funding for the entire Medicare program exceeds 45%. Provisions affecting the State Childrens' Health Insurance Program (SCHIP) and Medicaid programs are included in the legislation as well.

Earlier this year, under Congress' FY2004 budget resolution, \$400 billion was reserved for Medicare modernization, creation of a prescription drug benefit, and, in the Senate, to promote geographic equity payment. The Congressional Budget Office (CBO) has estimated that the legislation for H.R. 1 would increase direct (or mandatory) spending by \$394.3 billion from FY2004 through FY2013. Prescription drug spending is estimated at \$409.8 billion over the 10-year period and Medicare Advantage spending at \$14.2 billion. Overall, the fee-for-service provisions which change traditional Medicare are estimated to save \$21.5 billion over the 10-year period and adjusting the Part B premium to beneficiaries' income is estimated to save \$13.3 billion over the period. Some fee-for-service provisions will increase spending over this 10-year period including the provisions affecting hospitals and physician. Other fee-for-service provisions are projected to save money over the period including those affecting durable medical equipment, clinical laboratories and home health agencies. The CBO estimate is available on the CBO website at <ftp://ftp.cbo.gov/48xx/doc4808/11-20-MedicareLetter.pdf>.

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On November 22, 2003, the House of Representatives voted 220 to 215 to approve the conference report on H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Senate, on November 24th, voted 54 to 44 to approve the conference report. The bill was signed by the President in a ceremony on December 8th. The legislation adds a prescription drug benefit to Medicare and replaces the existing Medicare+Choice program with a new Medicare Advantage program that establishes managed care payments based on a system of bids and benchmarks. The bill also contains numerous provisions that would generally increase fee-for-service payments within Medicare's Part A and Part B program (also known as traditional Medicare), especially for rural health care providers; numerous regulatory and administrative practices will also be modified. This report discusses the fee-for-service (FFS) provisions of the legislation, those affecting Medicaid as well as the Medicare cost containment provisions¹. It compares the provisions in the bill as enacted with those in the Medicare reform bills that were originally passed by the Senate and the House.

The Medicare FFS provisions in the bill are found primarily in Titles GGIII through VIII; some FFS provisions are included in Titles VIII through X as noted. The cost containment provisions are in Title VIII and the Medicaid and other provisions are in Title X. An overview of the entire legislation can be found in CRS Report RL31966.

Changes to Medicare's Fee for Service Program

The legislation contains extensive changes to Medicare's FFS program, including payment increases and, in certain instances, decreases; development of competitive acquisition programs; implementation or refinement of other prospective payment systems (notably, the development of an end-stage renal disease (ESRD) basic payment system); expansion of covered preventive benefits; establishment of demonstration programs; and required studies. The anticipated financial impact of these changes on any individual provider, physician, or supplier will vary depending on many factors, such as the unique characteristics of the individual or entity participating in Medicare as well as the number and type of services provided to the Medicare beneficiaries they serve. Selected highlights of the FFS payment provisions and those establishing preventive care benefits and demonstration programs will be briefly described.

Selected Rural Provider Provisions

Generally, Medicare payments to certain rural providers are expected to increase; many of the rural provisions will benefit urban providers as well. CBO estimates that the rural provisions in Title IV of the bill will increase Medicare's direct spending by \$9.3 billion from 2004 through 2008 and by \$19.9 billion from 2004 through 2013. It should be noted that other provider payment provisions in H.R. 1 can impact rural providers, but their effect on Medicare payments to rural providers has not been specifically identified.

- **Hospitals** in rural areas and those in small urban areas will receive a permanent 1.6% increase to Medicare's base rate or per discharge payment; the payment limit for rural and small urban hospitals that qualify for disproportionate share hospital (DSH) adjustment will increase from 5.25% to 12%; hospitals in low-wage areas (those with wage index values below 1) will receive additional payments through a decrease from 71% to 62% in the labor-related portion of the base payment rate; and small rural hospitals with less than 50 beds will receive cost

¹ Cost containment provisions require an analysis of general tax revenue financing of the Medicare program as well as a Presidential and Congressional response when "excess general revenue financing of Medicare" exceeds a threshold of 45%.

reimbursement for outpatient clinical laboratory tests. In addition, rural hospitals with less than 100 beds will be protected from payment declines associated with the hospital outpatient prospective payment system (OPPS) for an additional 2 years; these OPPS hold harmless provisions will be extended to sole community hospitals for services from 2004 through 2006. CBO estimates that these provisions will increase direct Medicare spending by \$15.6 billion over the 10-year period.

- **Critical access hospitals** (CAHs) will have their bed limit increased from 15 to 25; there will be no restriction on the number of these beds that can be used for acute care services at any one time. CAHs will be able to establish distinct part rehabilitation and psychiatric units of up to 10 beds that will not be included in the CAH bed count. Cost reimbursement of CAH services will increase to 101% of reasonable costs, starting January 1, 2004. Periodic interim payments for CAHs will be authorized. State authority to waive the 35-mile requirement for new entities to qualify as a CAH will be eliminated as of January 1, 2006. CBO estimates that these provisions will increase direct Medicare spending by \$900 million over the 10-year period.
- **Physicians** in newly established scarcity areas will receive a 5% increase in Medicare payments. Physicians in certain low-cost areas with geographic adjustment factors below 1 will receive payment increases so as to increase this factor to 1, starting in 2004 through 2006. CBO estimates that these provisions will increase direct Medicare spending by \$1.7 billion over the 10-year period.
- **Practitioners** in rural health clinics and federally qualified health centers will be able to bill separately for services provided to beneficiaries in skilled nursing facilities. CBO estimates that these provisions will increase direct Medicare spending by \$100 million over the 10-year period.
- **Home health providers** in rural areas will receive a 5% increase in Medicare payments for one year beginning April 1, 2004. CBO estimates that this one-year increase will increase direct Medicare spending by \$100 million over the 10-year period.

Selected Acute Hospital Provisions

Generally, Medicare payments to hospitals will increase under the conference report. Specifically,

- Acute hospitals paid under the inpatient prospective payment system (IPPS) will receive the full increase in the market basket (MB) index as an update in 2004. From 2005 through 2007, hospitals that submit data on specified quality indicators will receive the MB as an update; those hospitals that do not submit such data will receive the MB minus 0.4 percentage points for the year in question. CBO expects that this provision will reduce direct spending 0.2 billion from 2004 through 2008.
- Teaching hospitals will receive an increase in their indirect medical education adjustment from 2004 through 2006 that CBO projects will increase spending by \$400 million.
- A one-time, geographic reclassification process to increase hospitals' wage index values for 3 years that is expected to increase payments by \$900 million from 2004 through 2008 is established.
- Low volume hospitals with fewer than 800 discharges that are 25 road miles away from similar hospitals may qualify for up to a 25% increase in Medicare payments for an expected cost of \$100 million from 2004-2013.
- Changes in payment methods for covered prescription drugs provided in outpatient hospital departments is expected to increase payments by \$700 million from FY2004 through FY2008.

- A redistribution of unused resident positions will increase both direct and indirect graduate medical education spending by an anticipated \$200 million from FY2004 through FY2008 and by \$600 million from FY2004 through FY2013.
- Certain teaching hospitals with high per resident payments will not receive a payment increase from FY2004 through FY2013; this provision was scored by CBO as a reduction in Medicare spending of \$500 million from FY2004 through FY2008 and \$1.3 billion from FY2004 through FY2013.
- For 18 months from the date of enactment, physicians will not be able to refer Medicare patients to specialty hospitals in which they have an investment interest. This provision will not apply to hospitals that are in operation or under development before November 18, 2003. Both MedPAC and HHS are to complete required studies on specialty hospitals within 15 months of enactment.

Selected Physician Provisions

The impact of the legislation on Medicare's spending for physician spending is difficult to determine. Although physicians will receive a 1.5% update in 2004 and 2005 which is expected to increase spending by \$2.8 billion from FY2004 through FY2007; subsequently, from FY2008 through FY2012, the provision is expected to result in a decline of \$2.8 billion in Medicare spending. Over the 10 year period from 2004 through 2013, CBO expects the update provisions to increase Medicare spending by \$200 million.

Medicare's payments for some practice expenses, particularly the administration of covered drugs, will increase starting in 2004. A transitional adjustment to the drug administration payments of 32% in 2004 and 3% in 2005 is also established. These payment increases are expected to be counterbalanced by a decrease in Medicare's payments for covered outpatient drugs provided in a doctor's office.

Medicare's payment for covered outpatient drugs furnished incident to a physician's service will change during 2004 as follows:

- Many covered outpatient drugs furnished in 2004 will be reimbursed at 85% of the average wholesale price (AWP). Certain of these drugs may be paid as low as 80% of the AWP (in effect as of April 1, 2003).
- Blood clotting factors and other blood products, drugs or biologicals (drug products) that were not available for payment by April 1, 2003, covered vaccinations, drug products furnished in during 2004 in connection with renal dialysis services, drugs provided through covered durable medical equipment will be paid at a higher rate during 2004.

The decline in payments for covered outpatient drugs in 2004 can only be implemented concurrently with the increased payments for the administration of the drugs.

Starting in 2005, Medicare's payment for many covered outpatient drugs will be based on average sales price methodology, that uses different pricing and cost data, depending on the prescription drug. Generally, multiple source drugs will be paid 106% of the average sales price; single source drugs will be paid 106% of the lower of the average sales price or the wholesale acquisition costs, unless the widely available market price or the average manufacturer price for those drugs exceeds a certain threshold. Starting in 2006, physicians will have the option of obtaining covered Part B drugs from selected entities awarded contracts for competitively biddable drug products under a newly established competitive acquisition program.

Selected Provisions Affecting Other Providers and Practitioners

The follow provisions affecting other providers and practitioners are included in the legislation:

Ambulatory Surgical Centers

Payments to ambulatory surgical centers (ASCs) are expected to be lower by \$800 million from FY2004 through FY2008 and by \$3.1 billion from FY2004 through FY2013 as a result of the legislation. ASCs will receive an update of the consumer price index for all urban consumers (CPI-U) minus 3.0 percentage points starting April 1, 2004 and will receive a 0 percent update for services provided starting October 1, 2004 through December 31, 2009.

Therapy Caps

Application of the caps on outpatient therapy services provided by non-hospital providers is suspended from the date of enactment and for the remainder of 2003, in 2004 and 2005. CBO estimates that the therapy cap moratorium will increase direct Medicare spending by \$700 million over the 10-year period.

Durable Medical Equipment (DME)

Competitive bidding for DME will be phased-in beginning in 2007 in 10 of the largest metropolitan statistical areas and may be phased in first for the highest cost and highest volume items and services. The update for most DME items and services and for prosthetics and orthotics is 0 in 2004, 2005, 2006, 2007, and 2008. For 2005, payment for certain items, oxygen and oxygen equipment, standard wheelchairs, nebulizers, diabetic lancets and testing strips, hospital beds and air mattresses will be reduced by an amount calculated using 2002 payment amounts and the median price paid by the Federal Employees Health Benefit Program.² Beginning January 1, 2009, items and services included in the competitive acquisition program will be paid as determined under that program and the Secretary can use this information to adjust the payment amounts for DME, off-the-shelf orthotics, and other items and services that are supplied in an area that is not a competitive acquisition area. Class III items (devices that sustain or support life, are implanted, or present potential unreasonable risk, e.g., implantable infusion pumps and heart valve replacements, and are subject to premarket approval, the most stringent regulatory control) receive the full increase in the consumer price index for all urban consumers (CPI-U) in 2004, 2005, 2006, 2008 and subsequent years. The Secretary will determine the update in 2007. CBO scored the DME provisions of the bill as reducing spending by \$6.8 billion over the 10-year period.

Home Health

Home health agency payments are increased by the full market basket percentage for the last quarter of 2003 (October, November, and December) and for the first quarter of 2004 (January, February, and March). The update for the remainder of 2004 and for 2005 and 2006 is the home health market basket percentage increase minus 0.8 percentage points. CBO estimates that this provision will reduce direct Medicare spending by \$6.5 billion over the 10-year period. The legislation suspends the requirement that home health agencies must collect the Outcome and

² Section 302 specifies that the reduction uses the "Median FEHP Price" in the table entitled "Summary of Medicare Prices Compared to VA, Medicaid, Retail, and FEHB Prices for 16 Items" that was included in testimony of the Health and Human Services Inspector General before the Senate Committee on Appropriations, June 12, 2002, or any subsequent report by the Inspector General.

Assessment Information Set (OASIS) data on private pay (non-Medicare, non-Medicaid) until the Secretary reports to Congress and publishes final regulations regarding the collection and use of OASIS.

Selected Fee-for Service Demonstration Projects

The legislation establishes numerous demonstration projects for the Medicare program. Several demonstrations address aspects of disease management for beneficiaries with chronic conditions.

Chronic Care Improvement under Fee-For-Service

The legislation requires the Secretary to establish and implement chronic care improvement programs under fee-for-service Medicare to improve clinical quality and beneficiary satisfaction and achieve spending targets specified by the Secretary for Medicare for beneficiaries with certain chronic health conditions. Participation by beneficiaries is voluntary. The contractors are required to assume financial risk for performance under the contract. CBO has estimated that this demonstration will increase direct Medicare spending by \$500 million over the 10-year period.

Chronically Ill Beneficiary Research, Demonstration

The legislation requires the Secretary to develop a plan to improve quality of care and to reduce the cost of care for chronically ill Medicare beneficiaries within 6 months after enactment. The plan is required to use existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill Medicare beneficiaries. The Secretary is required to implement the plan no later than 2 years after enactment.

Coverage of Certain Drugs and Biologicals Demonstration

The Secretary is required to conduct a 2-year demonstration where payment is made for certain drugs and biologicals that are currently provided as “incident to” a physician’s services under Part B. The demonstration is required to provide for cost-sharing in the same manner as applies under Part D of Medicare. The demonstration is required to begin within 90 days of enactment and is limited to 50,000 Medicare beneficiaries in sites selected by the Secretary.

Homebound Demonstration

The Secretary is required to conduct a 2-year demonstration project where beneficiaries with chronic conditions would be deemed to be homebound in order to receive home health services under Medicare.

Adult Day Care

The Secretary is required to establish a demonstration where beneficiaries could receive adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary’s home.

Expansion of Covered Benefits

The legislation contains a number of provisions that expand coverage beginning January 1, 2005, including the following:

Initial Physical Examination

Medicare coverage of an initial preventive physical examination is authorized for those individuals whose Medicare coverage begins on or after January 1, 2005. CBO estimates that this provision will increase direct Medicare spending by \$1.7 billion over the 10-year period.

Cardiovascular Screening Blood Tests

Medicare coverage of cardiovascular screening blood tests is authorized. CBO estimates that this provision will increase direct Medicare spending by \$300 million over the 10-year period.

Diabetes Screening Tests

Diabetes screening tests furnished to an individual at risk for diabetes for the purpose of early detection of diabetes are included as a covered medical service. In this instance, diabetes screening tests include fasting plasma glucose tests as well as other tests and modifications to those tests deemed appropriate by the Secretary. CBO estimates that this provision will increase direct Medicare spending less than \$50 million over the 10-year period.

Screening and Diagnostic Mammography

Screening mammography and diagnostic mammography will be excluded from OPPS and paid separately. CBO estimates that this provision will increase direct Medicare spending by \$200 million over the 10-year period.

Intravenous Immune Globulin

The bill includes intravenous immune globulin for the treatment in the home of primary immune deficiency diseases as a covered medical service under Medicare. CBO estimates that this provision will increase direct Medicare spending by \$100 million over the 10-year period.

Beneficiary Payments

The bill contains two provisions which change the beneficiary premiums and deductibles.

Income-Relating the Part B Premium

The legislation increases the monthly Part B premiums for higher income enrollees beginning in 2007. Beneficiaries whose modified adjusted gross income exceed \$80,000 and couples filing joint returns whose modified adjusted gross income exceeds \$160,000 will be subject to higher premium amounts. The increase will be calculated on a sliding scale basis and will be phased-in over a five-year period. The highest category on the sliding scale is for beneficiaries whose modified adjusted gross income is more than \$200,000 (\$400,000 for a couple filing jointly). Those amounts are increased beginning in 2007 by the percentage change in the consumer price index. CBO estimates that direct Medicare spending will be reduced by \$13.3 billion over the 10-year period 2004 through 2013.

Indexing the Part B Deductible

The Medicare Part B deductible will remain \$100 through 2004, increase to \$110 for 2005, and in subsequent years the deductible will be increased by the same percentage as the Part B premium

increase. Specifically, the annual percentage increase in the monthly actuarial value of benefits payable from the Federal Supplementary Medical Insurance Trust Fund will be used as the index.

Medicaid and Miscellaneous Provisions

Title X of the legislation makes some changes to Medicaid and other programs. Omitted from the agreement were two provisions contained in S. 1, including a provision to amend the Age Discrimination in Employment Act of 1967 to allow an employee benefit plan to offer different benefits to their Medicare eligible employees than to their non-Medicare eligible employees, and a provision to allow states to cover certain lawfully residing aliens under the Medicaid program.

CBO estimates the Medicaid and other provisions included in the bill to increase direct spending by \$5.7 billion between FY2004 and FY2013. The following general points can be made about the Medicaid and Miscellaneous provisions included in Title X of the bill:

- The legislation temporarily increases states' disproportionate share hospital (DSH) allotments to erase the decline in these Medicaid amounts that occurred after a special rule for their calculation expired.
- The legislation includes several other Medicaid provisions, including raising the floor on DSH allotments for "extremely low DSH states," providing DSH allotment adjustments impacting Hawaii and/or Tennessee, increasing reporting requirements for DSH hospitals, and exempting prices of drugs provided to certain safety net hospitals from Medicaid's best price drug program.
- Miscellaneous provisions in Title X of the legislation include funding federal reimbursement of emergency health services furnished to undocumented aliens, and funding administrative start-up costs for Medicare reform, various research projects, work groups and infrastructure improvement programs for the health care system.

This report contains a detailed side-by-side comparison of the relevant provisions of the legislation, S. 1, as passed the Senate, and H.R. 1, as passed the House. Certain of the provisions can be found in one or more of the sections. For example, the home health homebound demonstration (section 702) is listed in the home health section and the demonstration projects section. Also included in this side-by-side, are provision that were included in the House and/or Senate bill which were dropped in conference.

Modifications to Fee-for-Service Medicare

Provisions Relating to Part A

Hospital Services

Provision and Current Law Description	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Inpatient Prospective Payment System (IPPS) Hospitals			
Increase standardized amounts for small urban and rural hospitals in Medicare's inpatient hospital prospective payment system (IPPS). Medicare pays for inpatient services in acute hospitals in large urban areas using a standardized amount that is 1.6% larger than the standardized amount used to reimburse hospitals in other areas (both rural areas and smaller urban areas). P.L. 108-7 provided that all Medicare discharges from April 1, 2003 to September 30, 2003, will be paid on the basis of the large urban area amount. The Secretary is authorized to delay implementation of this payment increase until November 1, 2003, if necessary.	Section 401. Medicare will pay hospitals in rural and small urban areas in the 50 states using the standardized amount that would be used to pay hospitals in large urban areas starting for discharges in FY2004. The existing authority of the Secretary to delay implementation of this increase until November 1, 2003 for hospitals that are not in Puerto Rico is not affected. The Secretary will compute one local standardized amount for all hospitals in Puerto Rico equal to that for hospitals in large urban areas in Puerto Rico starting for discharges in FY2004. Hospitals in Puerto Rico will receive the legislated payment increase starting for discharges on April 1, 2004.	Section 401. Medicare would pay hospitals in rural and small urban areas in the fifty states using the standardized amount used to pay hospitals in large urban areas starting for discharges in FY2004. The Secretary would compute one standardized amount for hospitals in Puerto Rico equal to that for other areas.	Section 402. Similar provision with respect to discharges in the fifty states. Two standardized amounts would still be used for hospitals in Puerto Rico; one federal amount would be used in the calculation of these 2 rates.
Under Medicare's IPPS, two different standardized amounts are used for hospitals in Puerto Rico, one for hospitals in large urban areas and one for other hospitals.			
Increase payments to hospitals in areas with wage index values below one (by lowering Medicare's IPPS labor-related share which is the proportion of the standardized amount multiplied by the wage index). IPPS payments are adjusted, either increased or decreased as	Section 403. For discharges on or after October 1, 2004, the Secretary is required to decrease the labor-related share to 62% of the standardized amount when such change will result in higher total payments to the hospital. This provision is to be applied without regard to certain budget-	Section 402. For cost reporting periods beginning October 1, 2004, the Secretary would be required to decrease the labor-related share to 62% of the standardized amount only if such change would result in higher total payments to the hospital. This provision would be applied without regard to certain budget neutrality requirements.	Section 416. Same provision except that the effective date is October 1, 2003.

Provision and Current Law Description	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
appropriate, by the hospital wage index of the area where the hospital is located or where it has been reassigned. Presently, approximately 71% of the standardized amount is adjusted by the area wage index.	neutrality requirements. For discharges on or after October 1, 2004, the Secretary is also required to decrease the labor-related share to 62% of the standardized amount for hospitals in Puerto Rico when such change results in higher total payments to the hospital.		
Increase Medicare IPPS payments for low-volume hospitals. Medicare pays inpatient acute hospital services for each discharge from the hospital without regard to the number of beneficiaries discharged from any given hospital. Under certain circumstances, however, sole community hospitals (SCHs) and Medicare dependent hospitals with more than a 5% decline in total discharges from one period to the next may apply for an adjustment to their payment rates to partially account for higher costs associated with a drop in patient volume due to circumstances beyond their control.	Section 406. The Secretary is required to provide for a graduated adjustment of up to 25% of Medicare's inpatient payment rates to account for the empirically established higher unit costs associated with low-volume hospitals starting for discharges occurring in FY2005. A low-volume hospital is a short-term general hospital that is located more than 25 road miles from another such hospital and that has less than 800 discharges during the fiscal year. Certain budget neutrality requirements would not apply to this provision. The determination of the percentage payment increase is not subject to administrative or judicial review.	Section 403. The Secretary would be required to develop a graduated adjustment of up to 25% of Medicare's inpatient payment rates to account for the higher unit costs in low-volume hospitals. Certain hospitals with fewer than 2,000 total discharges during the three most recent cost reporting periods would be eligible for up to a 25% increase in their Medicare payment amount starting with cost reports that begin during FY2005. Eligible hospitals would be located at least 15 miles from a similar hospital or those determined by the Secretary to be so located due to factors such as weather conditions, travel conditions, or travel time to the nearest alternative source of appropriate inpatient care. Certain budget neutrality requirements would not apply.	No provision.
Increase disproportionate share hospital (DSH) payments for small urban and rural hospitals. Medicare makes additional payments to certain acute hospitals that serve a large number of low-income Medicare and Medicaid patients. Although a SCH or rural referral center (RRC) can qualify for a higher DSH adjustment, generally, the DSH adjustment that a small urban or rural hospital can receive is limited to a maximum of a 5.25% increase to its IPPS payment. Large (100 beds and more) urban hospitals and large rural hospitals (500 beds and more) are eligible for a higher adjustment that can be significantly greater; the amount of the DSH adjustment received by these larger	Section 402. Starting for discharges after April 1, 2004, a hospital that is not a large urban hospital that qualifies for a DSH adjustment will receive its DSH payments using the current DSH adjustment formula for large urban hospitals, subject to a limit. The DSH adjustment for any of these hospitals, except for rural referral centers, will be capped at 12%. A Pickle hospital receiving a DSH adjustment under the alternative formula will not be affected by this provision. (For a description of Pickle hospitals, see page 12 column 1.)	Section 404. Starting for discharges after October 1, 2004, a hospital that qualifies for a DSH adjustment when its DSH patient percentage exceeds the 15% DSH threshold would receive the DSH payments using the current formula that establishes the DSH adjustment for a large urban hospital.	Section 401. Starting for discharges after October 1, 2003, a hospital that is not a large urban hospital that qualifies for a DSH adjustment would receive its DSH payments using the current DSH adjustment formula for large urban hospitals, subject to a limit. The DSH adjustment for any of these hospitals, except for RRCs, would be capped at 10%.

Provision and Current Law Description	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
hospitals will depend upon its DSH patient percentage (the percentage of low-income Medicare or Medicaid patients served).			
Require MedPAC report on Medicare DSH adjustments. No provision in current law.	No provision.	Section 404A. MedPAC would be required to conduct a study to determine (1) whether DSH payments should be made in the same manner as Medicare's graduate medical education payments; (2) the extent that hospitals receiving Medicaid DSH payments also receive Medicare DSH payments; and (3) whether uncompensated care costs should be added to the Medicare DSH formula. The report, including recommendations, would be due to Congress within 1 year from enactment.	No provision.
Exclude wage data of hospitals that convert to critical access hospitals (CAHs) from IPPS wage index. Certain qualified small hospitals are converting to CAHs. After conversion, these facilities are paid on a reasonable cost basis and are not paid under IPPS. Medicare's IPPS payments to acute hospitals are adjusted by the wage index of the area where the hospital is located or has been reassigned. Although the hospital wage index is recalculated annually, the wage index for any given fiscal year is based on data submitted as part of a hospital's cost report from 4 years previously. As of FY2004, wage data from hospitals that have converted to CAHs were excluded from the IPPS wage index calculation.	No provision.	Section 405(e). The Secretary would be required to exclude wage data from hospitals that have converted to CAHs from the IPPS wage index calculation starting for cost reporting periods beginning January 1, 2004.	No provision.

Provision and Current Law Description	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Increase DSH for “Pickle” hospitals. Most DSH hospitals receive additional Medicare payments because they serve a disproportionate share of poor Medicare and Medicaid patients. A few urban hospitals receive DSH payments under an alternative Pickle formula. If a hospital receives at least 30% of its patient care revenue from indigent care funds, it will get a 35% increase in its Medicare operating payments. The Pickle hospitals receive a capital DSH adjustment of 14.16%, the amount that other non-Pickle hospitals with a 35% operating DSH adjustment would receive.</p>	No provision.	<p>Section 420A. Hospitals that qualify for the DSH adjustment under the Pickle amendment would receive a DSH operating and capital adjustment of 40% for discharges beginning October 1, 2003.</p>	No provision.
<p>Increase payments for hospitals in Puerto Rico. Under Medicare’s IPPS, separate standardized amounts are used to pay short-term general hospitals in Puerto Rico. The Balanced Budget Act of 1997 (BBA 97) provides for an adjustment of the Puerto Rico rates from blended amounts based on 25% of the national amounts and 75% of the local amounts to blended amounts based on a 50/50 split between national and local amounts.</p>	<p>Section 504. Hospitals in Puerto Rico will receive Medicare payments based on a 50/50 split between federal and local amounts before April 1, 2004. Starting April 1, 2004 through September 30, 2004, payment will be based on 62.5% national amount and 37.5% local amount; this will change to 75% national and 25% local after October 1, 2004 and in subsequent years.</p>	<p>Section 409. Hospitals in Puerto Rico would receive Medicare payments based on a 50/50 split between national and local amounts before October 1, 2004. These hospitals would receive Medicare payments based on 100% of the federal rate for discharges beginning October 1, 2004 and before October 1, 2009. The rate for hospitals in Puerto Rico would revert to a 50/50 split after October 1, 2009.</p>	<p>Section 503. From FY2004 though FY2007, hospitals in Puerto Rico would receive an increasing amount of the payment rate based on national rates as follows: during FY2004, payment would be 59% national and 41% local; during 2005, payment would be 67% national and 33% local and 75% national and 25% local during FY2006 and subsequently.</p>
<p>Require GAO report on appropriateness of IPPS payments. No provision in current law.</p>	No provision.	<p>Section 413. Using the most current data, the Comptroller General (GAO) would be required to report to Congress within 18 months of enactment on: (1) the appropriate level and distribution of IPPS Medicare payments to short-term general hospitals; and (2) the need for geographic adjustments to reflect legitimate differences in hospital costs.</p>	No provision.
<p>Calculate wage indices for hospitals. IPPS hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification to a different area. If reclassification is granted, the new wage index will be used to calculating Medicare’s payment for inpatient</p>	<p>Section 508. The Secretary will establish a wage index appeals process by January 1, 2004. A hospital seeking to be reclassified must submit an appeal to the MGCRB no later than February 15, 2004. Reclassifications will be effective for a 3-year period starting April 1, 2004. There</p>	<p>Section 419. The Secretary would be able to waive established reclassification criteria in calculating the wage index in a state when making payments for hospital discharges in FY2004.</p>	No provision.

Provision and Current Law Description	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
and outpatient services. The reclassification standards are established by regulation.	will be no further administrative or judicial review of these decisions. The additional spending associated with this provision cannot exceed \$900 million.		
Update hospital market basket more frequently. IPPS standardized amounts are increased annually using an update factor which is determined in part by the projected increase in the hospital market basket (MB), an input price index which measures the average change in the price of goods and services hospitals purchased in order to furnish inpatient care. Centers for Medicare and Medicaid Services (CMS) revises the category weights, reevaluates the price proxies for such categories, and rebases the MB every 5 years.	Section 404. The Secretary is required to revise the market basket weights to reflect the most currently available data and to establish a schedule for revising the cost category weights more often than once every 5 years. The Secretary is required to publish the reasons for and the options considered in establishing such a schedule in the final rule establishing FY2006 inpatient hospital payments.	No provision	Section 404. The Secretary would be required to revise the market basket cost weights to reflect the most currently available data and to establish a schedule for revising the weights more often than once every 5 years. The Secretary would be required to submit a report to Congress by October 1, 2004 on the reasons for and the options considered in establishing such a schedule.
Reduce hospital update factor. Each year, Medicare's operating payments to hospitals are increased or updated by a factor that is determined in part by the projected annual change in the hospital MB. Congress establishes the update for Medicare's IPPS for operating costs, often several years in advance. Currently, acute care hospitals will receive the MB as an update for FY2004 and subsequently.	Section 501. Acute hospitals will receive the MB as the operating update for FY2004. From FY2005 through FY2007, hospitals that submit required quality data will receive the MB as an update; hospitals that do not submit such data will receive the MB minus 0.4 percentage points. The reduction would apply to the year in question only and would not be taken into account in subsequent years. The operating update will be the MB in FY2008 and in subsequent years.	No provision.	Section 501. Acute hospitals would receive an operating update of the MB minus 0.4 percentage points for FY2004 through FY2006. The operating update would be the MB increase in FY2007 and subsequently.
Increase pass-through payments for new inpatient technology. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established that Medicare's IPPS should recognize the costs of new medical services and technologies beginning October 1, 2001. The additional hospital payments can be made by the means of new technology groups, an add-on payment, a payment adjustment, or other	Section 503. The Secretary is required to add new diagnosis and procedure codes in April 1 of each year but is not required to change Medicare's payment or DRG classification as a result of these additions until the fiscal year that begins after that date. When establishing whether DRG payments are inadequate, the Secretary is required to apply a threshold that is the lesser of 75% of the standardized amount (increased to reflect the difference	No provision.	Section 502. New diagnosis and procedure codes would be added in April 1 of each year that would affect Medicare's IPPS starting the following October. The Secretary would not be able to deny new technology status because an item has been used prior to the 2-to-3 year period before it was issued a billing code. When establishing whether DRG payments are

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<p>mechanism, but cannot be a separate fee schedule and must be budget neutral. CMS established that a technology that provided a substantial improvement to existing treatments would qualify for additional payments. The add-on payment for an eligible new technology would occur when the standard diagnosis related group (DRG) payment was inadequate. This threshold was established as one standard deviation above the mean standardized DRG; the add-on payment for new technology would be the lesser of: (a) 50% of the costs of the new technology; or (b) 50% of the amount by which the costs exceeded the standard DRG payment. However, if the new technology payments are estimated to exceed the budgeted target amount of 1% of the total operating inpatient payments, the add-on payments are reduced prospectively. CMS has proposed to reduce the threshold to 75% of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new service is assigned.</p>	<p>between costs and charges) or 75% of one standard deviation for the DRG involved. The Secretary is required to: (1) maintain a current public list of pending applications for this additional payment; (2) accept public comment, recommendations, and data regarding whether a service or technology represents a substantial improvement; and (3) provide for a public meeting with the clinical staff at CMS and organizations representing physicians, beneficiaries, manufacturers or other interested parties. These actions will occur prior to the publication of a proposed regulation. Before establishing an add-on payment as the appropriate reimbursement mechanism, the Secretary is directed to identify one or more DRGs and assign the technology to that DRG. When such assignment to a DRG occurs, no add-on payment would be made; the budget-neutrality requirement with respect to annual DRG reclassifications and recalculation will apply. Funding for new technology is no longer required to be budget neutral. The provisions will apply to new technology determinations beginning in FY2005. Applications that were denied in FY2005 will be reconsidered under these provisions; if granted, the maximum time period otherwise permitted for such classification as a new technology is extended by 12 months.</p>		<p>inadequate, the Secretary would be required to apply a threshold that is the lesser of 75% of the standardized amount (adjusted to reflect the difference between costs and charges) or 75% of one standard deviation for DRG involved. The Secretary would be required to provide additional regulatory guidance on the new technology criteria. The Secretary would be required to deem that a technology provides a substantial improvement on an existing treatment if it is designated under section 506 of the FDA Act, approved under certain sections of Title 21, designated for priority review, is an exempt medical device under section 520(m) of such Act, or receives expedited review under section 515(d)(5). Other requirements requiring the process for public input would be imposed. A preference for use of a DRG adjustment would be established. Add-on payments would be increased to the percentage that Medicare reimburses inpatient outlier cases. Funding for this new technology would no longer be budget neutral.</p>
<p>Increase hospitals' wage index values to reflect commuting patterns from higher wage index areas. Unlike other providers, IPPS hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for reassignment to another area. The MGCRB was created to determine whether a hospital should be</p>	<p>Section 505. The Secretary is required to establish an application process and 3-year payment adjustment to recognize the out-migration of hospital employees who reside in a county and work in a different area with a higher wage index. A hospital that receives such a payment adjustment will be located in a qualifying county that meets</p>	<p>No provision.</p>	<p>Section 504. The Secretary would be required to establish an application process and payment adjustment to recognize the commuting patterns of hospital employees. A hospital that qualified for such a payment adjustment would have average</p>

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<p>redesignated to an area with which it has close proximity for purposes of using the other area's wage index. A hospital can establish proximity to the new area by documenting that at least 50% of its employees reside there. Other cost criteria must be met before a hospital will be reclassified. If reclassification is granted, the wage index for the new area will be used to calculate Medicare's payment for inpatient and outpatient services provided by the hospital.</p>	<p>certain criteria including (1) a threshold of no less than 10% for minimum out-migration to a higher wage index area or areas, and (2) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area where the county is located. The Secretary may require acute hospitals and other hospitals as well as critical access hospitals to submit data regarding the location of their employees' residence or the Secretary may use data from other sources. A hospital that receives a commuting wage adjustment is not eligible for reclassification into another area by the MCGRB. This adjustment is exempt from certain budget neutrality requirements. The thresholds and other qualifying criteria for the commuting wage adjustment are not subject to judicial review. The provisions apply to discharges on or after October 1, 2004.</p>		<p>hourly wages that exceed the average wages of the area in which it is located and have at least 10% of its employees living in one or more areas that have higher wage index values. The process would be based on the MGCRB reclassification process and schedule with respect to data submitted. Such an adjustment would be effective for 3 years unless a hospital withdraws or elects to terminate its payment. It would also be exempt from certain budget neutrality requirements.</p>
<p>Permit hospitals with missing cost reports to be SCHs. SCHs are hospitals that, because of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of inpatient services reasonably available in a geographic area, or are located more than 35 road miles from another hospital. An SCH receives the higher of the following payment rates: the current IPPS base payment rate, or its hospital-specific per discharge costs from either FY 1982, 1987 or 1996 updated to the current year. The FY1996 base year option will be fully implemented beginning in FY2004.</p>	<p>Section 407. A hospital will not be able to be denied treatment as a SCH or receive payment as a SCH because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data from at least one applicable base cost reporting period is available. The provision applies to cost reporting periods beginning on or after January 1, 2004.</p>	<p>No provision.</p>	<p>Section 414. Beginning January 1, 2004, a hospital would not be able to be denied treatment as a SCH or receive payment as a SCH because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data from at least one applicable base cost reporting period is available.</p>

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Provide hospitals with data on patient days for DSH adjustment. A hospital's DSH payments under IPPS are calculated using a formula that includes data on the number of total patient days as well as days provided to those eligible for Medicaid and to Medicare beneficiaries who receive Supplemental Security Income.	Section 951. The Secretary is required to provide information that hospitals need to calculate the number of Medicaid patient days used in the Medicare DSH payment formula not later than 1 year after enactment.	No provision.	Section 951. The Secretary would arrange to furnish necessary patient day information for the Medicare DSH computation for the current cost reporting year.
Permit adoption of new coding standard. The Secretary is required to rely on the recommendations from the National Committee on Vital and Health Statistics (NCVHS) before adopting health information standards and codes.	No provision.	No provision.	Section 942(d). The new coding standards, International Classification of Diseases 10 th Revision (ICD-10) could be adopted within 1-year of enactment without receiving a recommendation from NCVHS.
Require GAO report on use of external data for IPPS payments. No provision in current law.	Section 942(c). GAO is required to study which external data can be collected in a shorter time frame by CMS to use in calculating IPPS payments. GAO may evaluate feasibility and appropriateness of using quarterly samples or special surveys and would include an analysis of whether other executive agencies are best suited to collect this information. The report is due to Congress no later than October 1, 2004.	No provision.	Section 942(c). GAO would study which external data can be collected in a shorter time frame by CMS to use in calculating IPPS payments. GAO could evaluate feasibility and appropriateness of using quarterly samples or special surveys and would include an analysis of whether other executive agencies are best suited to collect this information. The report would be due to Congress no later than October 1, 2004.
Critical Access Hospital Services			
Increase payments to CAHs. Generally, a critical access hospital (CAH) receives reasonable cost reimbursement for care rendered to Medicare beneficiaries. CAHs may elect either a cost-based hospital outpatient service reimbursement or an all-inclusive rate which is equal to a reasonable cost reimbursement for facility services	Section 405(a). Inpatient, outpatient, and covered skilled nursing facility services provided by a CAH in its swing beds will be reimbursed at 101% of reasonable costs of services furnished to Medicare beneficiaries. This provision applies to cost reporting periods beginning on or after January 1, 2004.	No provision.	Section 405(a). Inpatient, outpatient, and covered skilled nursing facility services provided by a CAH in its swing beds would be reimbursed at 102% of reasonable costs of services furnished to Medicare beneficiaries. This provision would apply to cost reporting periods

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plus 115% of the fee schedule payment for professional services.			beginning on or after October 1, 2003.
Eliminate 35-mile requirement for cost-based reimbursement of CAH ambulance services. Ambulance services provided by a CAH or provided by an entity that is owned or operated by a CAH are paid on a reasonable cost basis and not the ambulance fee schedule, if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH.	No provision.	Section 405(b). The requirement that the CAH or the related entity be the only ambulance provider within a 35-mile drive in order to receive reasonable cost reimbursement for the ambulance services would be dropped for services furnished beginning January 1, 2005.	Section 405(c). The 35-mile requirement would not apply to a provider or supplier of ambulance services who is a first responder to emergencies for services furnished after the first cost reporting period beginning after the date of enactment.
Expand payment for emergency room on-call providers. BIPA required the Secretary to include the costs of compensation (and related costs) of on-call emergency room physicians who are not present on the premises of a CAH, are not otherwise furnishing services, and are not on-call at any other provider or facility when determining the allowable, reasonable cost of outpatient CAH services.	Section 405(b). The provision expands reimbursement of on-call emergency room providers to include not just emergency room physicians but also physician assistants, nurse practitioners, and clinical nurse specialists for the costs associated with covered Medicare services provided beginning January 1, 2005.	Section 405(c). Reimbursement for on-call emergency room providers would be expanded to include physician assistants, nurse practitioners, and clinical nurse specialists as well as emergency room physicians for covered Medicare services provided beginning January 1, 2005.	Section 405(b). Same provision but would be effective January 1, 2004.
Increase critical access hospital (CAH) bed limit. A CAH is a limited service facility that must provide 24-hour emergency services and operate a limited number of inpatient beds in which hospital stays can average no more than 96 hours. A CAH is limited to 15 acute-care beds, but can have an additional 10 swing beds that are set up for skilled nursing facility level care. While all 25 beds in a CAH can be used as swing beds, only 15 of the 25 can be used for acute care at any time.	Section 405(e). A CAH will be able to operate up to 25 beds. The requirement that only 15 of the 25 beds be used for acute care at any time is dropped. The provision applies to CAH designations made before, on, or after January 1, 2004, but any election made pursuant to the regulations promulgated to implement this provision will only apply prospectively.	Section 405(a) A CAH would be able to operate up to 25 swing beds or acute care beds, subject to the 96-hour average length of stay for acute care patients. The requirement that only 15 of the 25 beds be used for acute care at any time would be dropped. This provision would be effective for designations made beginning October 1, 2004.	Section 405(f). For designations beginning January 1, 2004, the Secretary would specify standards for establishing seasonal variations in a CAH's patient admissions that would justify a five-bed increase in the number of beds it can maintain (and still retain its classification as a CAH). CAHs with swing beds would be able to use up to 25 beds for acute care services as long as no more than 10 beds at any time are used for non-acute services. Those CAHs with swing beds that made this election would not be eligible for the five-bed seasonal adjustment. A CAH with swing beds that elects to operate

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			15 of its 25 beds as acute care beds would be eligible for the five-bed seasonal adjustment.
Authorize periodic interim payments for eligible CAHs. Eligible hospitals, skilled nursing facilities, and hospices which meet certain requirements receive Medicare periodic interim payments (PIP) every 2 weeks; these payments are based on estimated annual costs without regard to the submission of individual claims. At the end of the year, a settlement is made to account for any difference between the estimated PIP payment and the actual amount owed. A CAH is not eligible for PIP payments.	Section 405(c). An eligible CAH will be able to receive payments made on a PIP basis for its inpatient services. The Secretary is required to develop alternative methods for the timing of PIP payments to these CAHs. This provision applies to payments made on or after July 1, 2004.	Section 405(d). Starting with payments made beginning January 1, 2005, an eligible CAH would be able to receive payments made on a PIP basis for inpatient services.	Section 405(d). Same provision but would be effective January 1, 2004. Also, the Secretary would be required to develop alternative methods based on the expenditures of the hospital for these PIP payments.
Exclude beds in distinct-part units from CAH bed count Beds in distinct-part skilled nursing facility units do not count toward the CAH bed limit. Beds in distinct-part psychiatric or rehabilitation units operated by an entity seeking to become a CAH count toward the bed limit.	Section 405(g). A CAH can establish a distinct part psychiatric or rehabilitation unit that meets the applicable requirements for such beds. If the units do not meet these requirements during a cost reporting period, then no Medicare payment will be made to the CAH for services furnished in the unit during the period in question. Payments for services provided in these units will equal payments that are made on a prospective payment basis to distinct part units of short term general hospitals. The beds in the distinct part psychiatric or rehabilitation units will not count toward the CAH bed limit. The total number of beds in these distinct part units cannot exceed 10. The provision will apply to cost reporting periods starting October 1, 2004	Section 405(g). The Secretary would not be able to count any beds in a distinct-part psychiatric or rehabilitation unit operated by the entity seeking to become a CAH for designations beginning October 1, 2003. The total number of beds in these distinct-part units would not be able to exceed 25. A CAH would be able to establish a such a distinct-part unit.	No provision.
Establish CAH improvement demonstration program. No provision in current law.	No provision.	Section 415. The Secretary would be required to establish a budget neutral 5-year CAH demonstration program in four areas including Kansas and Nebraska to test various methods to improve the CAH program. Services would be paid either on the basis of its reasonable costs (without regard to customary charges) or using the relevant PPS for those services. In this	No provision.

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		instance, reasonable cost reimbursement of capital would include a return on equity payment of 150% of the average rate of interest paid by the Hospital Insurance (HI) Trust Fund.	
Modify CAHs' billing requirements for physician services. As specified by Balanced Budget Refinement Act of 1999 (BBRA), CAHs can elect to be paid for outpatient services using cost-based reimbursement for its facility fee and at 115% of the fee schedule for professional services otherwise included within its outpatient critical access hospital services for cost reporting periods starting October 1, 2000.	Section 405(d). The requirement that all physicians or practitioners providing services in a CAH assign their billing rights to the entity in order for the CAH to be able to be paid 115% of the fee schedule cannot be imposed. However, a CAH will not receive payment based on 115% of the fee schedule for any individual who does not assign billing rights to the CAH. This provision applies to cost report periods starting on or after July 1, 2004 except for those CAHs that have already elected payment for physician services on this basis before November 1, 2003; this provision will apply to those CAHs starting for cost reporting periods on or after July 1, 2003.	No provision.	Section 405(e). The Secretary would not be able to require that all physicians providing services in a CAH assign their billing rights to the entity in order for the CAH to be able to be paid on the basis of 115% of the fee schedule for the professional services provided by the physicians. However, a CAH would not receive such payment for any physician who did not assign billing rights to the CAH.
Eliminate state authority to waive CAH mileage requirements. Currently, to qualify as a CAH, the rural, for-profit, nonprofit, or public hospital must be located more than 35 miles from another hospital or 15 miles in areas with mountainous terrain or those where only secondary roads are available. These mileage standards may be waived if the hospital has been designated by the State as a necessary provider of health care.	Section 405(h). The State will no longer be able to waive the mileage standards and designate a facility seeking to become a CAH as a necessary provider of care after January 1, 2004. A facility designated as CAH before January 1, 2006 and certified as a necessary provider of care will be able retain such designation.	No provision.	No provision.
Other Hospitals			
Create essential rural hospital category. Generally, a hospital designated as a CAH is exempt from IPPS and receives reasonable, cost-based reimbursement for care rendered to Medicare beneficiaries. Certain acute general hospitals receive special treatment under IPPS, particularly those facilities identified as isolated or	No provision.	No provision.	Section 403. The definition of CAH hospital and services would be amended to add an essential rural hospital. An eligible hospital would apply for such a classification, have more than 25 licensed acute care beds, and be located in a rural area as defined

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essential hospitals primarily located in rural areas, including RRCs and SCHs.			by IPPS. The Secretary would have to determine that the closure of this hospital would significantly diminish the ability of beneficiaries to obtain essential health care services based on certain criteria. Such hospitals would not be able to change such classification and would not be able to be treated as a SCH, Medicare dependent hospital or RRC under IPPS and would be reimbursed 102% of its reasonable costs for inpatient and outpatient services beginning October 1, 2004. Beneficiary cost-sharing amounts would not be affected and required billing for such services would not be waived.

Allied Health and Graduate Medical Education Payments

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Pay hospitals for training costs of psychologists. Medicare pays hospitals for its share of direct costs associated with approved hospital-based training programs for nurses and certain other allied health professionals including inhalation therapists, nurse anesthetists, occupational and physical therapists. Medicare does not pay for such costs associated with psychologists' training.	No provision. Discussion of congressional intent regarding this payment can be found on p. 276 of the Conference Report	Section 408. Beginning October 1, 2004, Medicare would reimburse its share of the reasonable costs of approved education activities of psychologists under the allied health professional training provisions.	No provision.
Increase initial residency period for geriatricians. Medicare counts residents in their initial residency period (the lesser of the minimum number of years required for board eligibility in the physician's specialty or 5 years) as 1.0 FTE. Residents whose training has extended beyond their initial residency	Section 712. The bill clarifies that Congress intended to provide an exception to the initial residency period for geriatric fellowship programs to accommodate programs that require 2 years of training to initially become board eligible in the geriatric specialty. The Secretary is required to promulgate interim	Section 410. The Secretary would be required to promulgate interim final regulations after notice and comment that would establish full GME payment for 2 years as a 2-year initial residency program for certain geriatric training programs effective	No provision.

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<p>period count as 0.5 FTE. Geriatrics is a subspecialty of family practice, internal medicine and psychiatry. A 1-year fellowship is required for certification in geriatrics, following an initial residency in one of those three areas.</p> <p>Increase indirect medical education (IME) payments. A hospital's IME payment is based on a percentage add-on to its IPPS rate that is established by a complicated curvilinear formula that currently provides a payment increase of approximately 5.5% for each 10% increase in the hospital's intern and resident-to-bed (IRB) ratio. The statutory formula is multiplied by a hospital's base payment rate for each Medicare discharge to determine the IME payments: $1.35 \times [(1 + \text{IRB})^{0.405} - 1]$. The multiplier of 1.35 increases the level of the IME adjustment to the existing target level of 5.5%. Congress has periodically changed the multiplier to decrease or increase IME payments to teaching hospitals.</p> <p>Count residents in a non-provider setting; drop dentists and podiatrists from the 3-year rolling limit on IME payments. Medicare has different resident limits for the IME adjustment and direct medical education (DGME) payment. Generally, the resident counts for both IME and DGME payments are based on the number of residents in approved allopathic and osteopathic teaching programs reported by the hospital in calendar year 1996. The DGME limit may differ from the IME limit because in 1996 residents training in non-hospital sites were eligible for DGME payments but not for IME payments. Prior to BBA 1997, the number of residents that could be counted for IME purposes included only those in the hospital inpatient and</p>	<p>final regulations consistent with this expressed intent after notice and subject to public comment. The regulations will be effective for cost reporting periods on or after October 1, 2003.</p> <p>Section 502. From April 1, 2004 until September 30, 2004, the IME multiplier is equal to 1.47; during FY2005, the IME multiplier is 1.42; during FY2006, the IME multiplier is 1.37; during FY2007, the IME multiplier is 1.32; and, starting October 1, 2007, the IME multiplier is equal to 1.35. This provision applies to discharges on or after April 1, 2004.</p> <p>Section 713. For a 12-month period starting January 1, 2004 hospitals will be able to count residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002 who are training at non-hospital setting without regard to the financial arrangement between the hospital and the teaching physician practicing in the non hospital site. The Inspector General of Health And Human Services (HHS-IG) will submit a study including recommendations on the appropriateness of the payment methodology for the volunteer supervision.</p>	<p>for cost reporting periods beginning October 1, 2003.</p> <p>Section 418. The IME multiplier in FY2004 and in FY 2005 would be 1.36; the multiplier would be 1.355 in FY2006 and in subsequent years. This would provide an IME adjustment of 5.508% for each 10% increase in a hospital's IRB ratio for FY2004 and FY2005. This change has been projected to increase payments to teaching hospitals by \$300 million over 10 years.</p> <p>Section 411. The Secretary would be required to reimburse teaching hospitals for residents in non-hospital locations, when hospitals incur all, or substantially all, the costs of the training in that site starting from the effective date of a written agreement between the hospital and the entity owning or operating the non-hospital site. The effective date of the written agreement would be determined according to generally accepted accounting principles. The Secretary would not be able to take into account the fact that the hospital costs incurred are lower than actual Medicare reimbursement. Starting with FY2005, dental and podiatric residents would be removed from the 3-year rolling average calculation for IME and DGME reimbursements.</p>	<p>No provision.</p> <p>No provision.</p>

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<p>outpatient departments. Effective October 1, 1997, under certain circumstances, a hospital may now count residents in non-hospital sites for the purposes of IME. Subject to these resident limits, a teaching hospital's IME and DGME payments are based on a 3-year rolling average of resident counts. The rolling average calculation includes podiatry and dental residents. CMS has proposed regulations that limit Medicare's medical education payments when existing residents are transferred from a non-hospital entity to a teaching hospital, particularly when the non-hospital entity has historically paid for the training costs without hospital funding.</p> <p>Extend update limitation on high cost programs. Hospitals with per resident amounts between 85% and 140% of the geographically-adjusted national average would continue to receive payments based on their hospital-specific per resident amounts updated for inflation.</p> <p>Redistribute unused residency positions. Medicare has different resident limits for the IME adjustment and DGME payment. Generally, the resident counts for both IME and DGME payments are based on the number of residents in approved allopathic and osteopathic teaching programs that were reported by the hospital for the cost reporting period ending in calendar year 1996. The DGME resident limit is based on the unweighted resident counts. It may differ from the IME limit because in 1996 residents training in non-hospital sites were eligible for DGME payments but not for IME payments. Generally, a hospital's IME adjustment and increased IPPS payments depends on a hospital's teaching intensity as measured by the ratio of the number of interns and residents per bed. Medicare's DGME</p>	<p>Section 711. Hospitals with per resident amounts above 140% of the geographically adjusted national average amount will not get an update from FY2004 through FY2013.</p> <p>Section 422. A teaching hospital's total number of resident positions will be reduced for cost reporting periods starting July 1, 2005 if its reference resident level is less than its applicable resident limit. Rural hospitals with less than 250 acute care inpatient beds would be exempt from these reductions. The reduction for other hospitals will equal 75% of the difference between the hospital's limit and its reference resident level. The reference resident level is the highest number of allopathic and osteopathic resident positions (before the application of any weighting factors) for the hospital during the reference period. This reference period is either (1) the resident level of the most recent cost reporting period of the hospital for which a cost report has been settled (or submitted, subject to audit) on or before September 30,</p>	<p>No provision.</p> <p>No provision.</p>	<p>Section 711. Hospitals with per resident amounts above 140% of the geographically-adjusted national average amount would not get an update from FY2004 through FY2013.</p> <p>Section 406. A teaching hospital's total number of Medicare-reimbursed resident positions would be reduced by a portion of its unused residency slots for cost reporting periods starting January 1, 2004 if its resident reference level is less than its applicable resident limit. If so, the reduction would be equal to 75% of the difference between the hospital's limit and its resident reference level upon the timely request for such an adjustment, for the cost reporting period that includes July 1, 2003. A hospital's reference period would be the three most recent settled or submitted consecutive cost reporting periods on or before September 30, 2002. The need for an increase in the physician specialty and the location involved would be considered. Positions would be distributed to programs</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
payment to teaching hospitals is based on its updated cost per resident (subject to a locality adjustment and certain payment corridors), the weighted number of approved full-time equivalent (FTE) residents, and Medicare's share of inpatient days in the hospital.	2002 or (2) the resident level for the cost reporting period that includes July 1, 2003 subject to audit. A hospital's reference level may be adjusted under certain circumstances. The increase in applicable resident limits applies to portions of cost reporting periods occurring on or after July 1, 2005. The aggregate increase may not exceed the overall reduction in such limits. The Secretary is directed to take several factors into account when distributing the resident positions to hospitals. No more than 25 additional FTEs will be given to any hospital. These hospitals will be reimbursed for DGME for the increase in resident positions at the locality adjusted national average per resident amount and will receive increased IME payments as well for discharges after July 1, 2005. The Secretary is required to submit a report to Congress no later than July 1, 2005 on whether to extend the application deadline for increases in resident limits.		in rural areas and those not in large urban areas on a first-come-first-served basis. The hospital would have to demonstrate that the resident positions would be filled; not more than 25 positions would be given to any hospital. These hospitals would be reimbursed for DGME for the increase in resident positions at the locality-adjusted national average per resident amount. IME payments would also be affected. The Secretary would be required to submit a report to Congress, no later than July 1, 2005, on whether to extend the application deadline for increases in resident limits.

Skilled Nursing Facility (SNF) and Hospice Services

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Skilled Nursing Facility Services (SNF)			
Increase skilled nursing facility (SNF) payments for AIDS patients. Under PPS, SNFs are paid a daily rate that varies depending on the care needs of the beneficiary. There are 44 resource utilization groups (RUGs) used to adjust payment for care needs; each group reflects the intensity of services, such as skilled nursing care and/or various therapy and other services needed by a beneficiary.	Section 511. Starting October 1, 2004, the per diem RUG payment for a SNF resident with acquired immune deficiency syndrome (AIDS) will be increased by 128%. This increase does not apply after the date that the Secretary certifies that the case-mix adjustment adequately compensates for the increased costs associated with caring for residents with AIDS.	No provision.	Section 511. Starting October 1, 2003, the per diem RUG payment for a SNF resident with acquired immune deficiency syndrome (AIDS) would be increased by 128%. This increase would not apply after the date that the Secretary certifies that the case-mix adjustment adequately compensates for the increased costs associated with caring for residents with AIDS.
Exclude certain clinic visits from skilled nursing facility (SNF) prospective	Section 410. Services provided to a SNF resident by a rural health clinic (RHC) and a	Section 429. Services provided by a RHC and a FQHC after January 1, 2005 would be	Section 408. Provision is limited to RHCs and FQHC services provided after January 1,

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>payment system (PPS) Under Medicare's PPS, SNFs are paid a predetermined amount to cover all services provided in a day adjusted for the care needs of the patient. Certain services and items provided a SNF resident, such as physicians' services, specified ambulance services, specified chemotherapy items and services, and certain outpatient services provided by a Medicare-participating hospital or CAH, are excluded from the SNF-PPS and paid separately under Part B.</p>	<p>federally qualified health center (FQHC) after January 1, 2005 are excluded from SNF-PPS if these services would have been excluded if furnished by a physician or practitioner who was not affiliated with a RHC or FQHC.</p>	<p>excluded from SNF-PPS if these services would have been excluded if furnished by a physician or practitioner who was not affiliated with a RHC or FQHC. Outpatient services that are beyond the general scope of SNF comprehensive care plans that are provided by an entity that is 100% owned as a joint venture by two Medicare-participating hospitals or critical access hospitals would be excluded from the SNF-PPS.</p>	<p>2004 and does not extend to outpatient services that are beyond the general scope of SNF comprehensive care plans.</p>
<p>Require background check on workers for certain Medicare and Medicaid health and long-term care providers. Nursing homes and home health agencies may request the Federal Bureau of Investigation (FBI) to search its all-state national data bank of arrest and convictions for the criminal histories of applicants who would provide direct patient care, as long as states establish mechanisms for processing these requests (most states require checks for certain groups of employees). Providers follow certain procedures to conduct these checks.</p> <p>HHS maintains a national health care fraud and abuse data base, the Healthcare Integrity and Protection Data Bank (HIPDB). Self-queries of HIPDB are allowed by government agencies, health plans, health care providers, suppliers and practitioners. All states also maintain their own registries of those persons that the state determines meet the requirements to work as nurse aides. Included in these registries are data describing state findings of resident neglect, abuse and/or the misappropriation of resident property.</p> <p>State survey agencies are required to investigate allegations of resident neglect, abuse and/or the misappropriation of resident property in nursing homes.</p>	<p>Section 306. The Secretary, in consultation with the Attorney General, is required to establish pilot projects on background checks for certain long-term care workers with direct access to patients or residents in no more than 10 states. The Secretary is required to establish criteria for selecting those states that volunteer to participate. The bill specifies procedures for conducting background checks, and includes searches of state and FBI criminal records. At least one state in the pilot project would be allowed to establish procedures for using employment agencies to conduct these checks. Providers may provisionally employ workers pending completion of the checks.</p> <p>The Secretary is required to pay those states for the costs of conducting the pilot program (reserving 4% of the payments for the program's evaluation). A sum of \$25 million is appropriated from funds in the Treasury not otherwise appropriated, for fiscal years 2004 through 2007.</p>	<p>Section 636. All providers of long-term care services that participate in Medicare and/or Medicaid would be required to initiate background checks for certain workers with access to a patient or resident. Procedures for conducting background checks would be specified, and would include searches of state and FBI criminal records. Violators of these requirements would be subject to criminal penalty fines and/or imprisonment. Providers would be permitted to provisionally employ workers pending completion of the checks and would be reimbursed for their costs of conducting these checks.</p> <p>The nurse aide registry would be expanded to include all employees of long-term care providers and renamed "employee registry." The investigatory responsibilities of survey and certification agencies would be expanded. \$10.2 million would be authorized to be appropriated for FY 2004, with compliance deadlines varying by provider group.</p> <p>Grants would be available to develop information on best practices in patient abuse prevention training and for other purposes.</p> <p>Long-term care providers could access the HIPDB data bank and more information would be required to be included. A report on background checks would be due to</p>	<p>No provision.</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
		Congress no later than 2 years after enactment.	
Hospice Services			
Permit hospices to provide core hospice services under arrangement. Medicare requires a hospice to provide certain core services directly. These core services include nursing care, medical social services, and counseling services.	Section 946. Beginning with the date of enactment, a hospice is permitted to enter into arrangements with another hospice program to provide core services in extraordinary circumstances.	Section 406. Beginning with the date of enactment, a hospice would be permitted to enter into arrangements with another hospice program to provide core service in extraordinary circumstances.	Section 946. Same provision.
Permit nurse practitioners, clinical nurse specialists, and physician assistants to attend hospice patients. Medicare covers hospice services to care for the terminal illness of a beneficiary. Reasonable and necessary medical and support services for the management of the terminal illness are furnished under a written plan-of-care established and periodically reviewed by the patient's attending physician and the hospice. The attending physician may be employed by the hospice and is identified by the beneficiary as having the most significant role in the determination and delivery of medical care to the beneficiary at the time that hospice care is elected.	Section 408. The definition of an attending physician in hospice is expanded to include a nurse practitioner. A nurse practitioner is not permitted to certify a beneficiary as terminally ill for the purposes of receiving the hospice benefit. The provision is effective upon enactment.	Section 407. Beginning October 1, 2004, a terminally ill beneficiary under hospice care would be able to designate a physician assistant, nurse practitioner, or clinical nurse specialist (who is not an employee of the hospice program) as his or her attending physician. The written plan-of-care would be able to be established by these professionals who would be able to periodically review the beneficiary's written plan-of-care.	Section 409. Nurse practitioners would be permitted to be identified as a beneficiary's attending physician and would be able to establish and review the written plan-of-care as well as provide other services, but would not be able to certify that a beneficiary is terminally ill.
Pay for physician consultation services in certain instances. Current law authorizes coverage of hospice services, in lieu of certain other Medicare benefits, for terminally ill beneficiaries who elect such coverage. The hospice can be paid by Medicare only after the beneficiary has elected the hospice benefit	Section 512. Beginning January 1, 2005, Medicare will pay for a hospice-employed physician's consultation with a terminally ill beneficiary who has not elected the hospice benefit.	No provision.	Section 512. As of January 1, 2004, Medicare would pay for a hospice-employed physician's consultation with a terminally ill beneficiary who has not elected the hospice benefit.
Establish rural hospice demonstration program. Medicare's hospice services are provided primarily in a patient's home to beneficiaries who are terminally ill and who elect such services. Medicare law prescribes that the aggregate number of days of inpatient care provided to Medicare beneficiaries who	Section 409. The Secretary is required to establish a demonstration project in 3 hospice programs to deliver hospice care to Medicare beneficiaries in rural areas. A project is not permitted to last longer than 5 years. Those Medicare beneficiaries who lack an appropriate caregiver and are unable to	No provision.	Section 418. The Secretary would establish a 5-year demonstration project in three hospice programs to deliver hospice care to Medicare beneficiaries in rural areas. Those Medicare beneficiaries who lack an appropriate caregiver and are unable to receive home-based hospice care would be

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
elect hospice care in any 12-month period cannot exceed 20% of the total number of days of hospice coverage provided to these persons.	receive home-based hospice care could receive hospice care in a facility of 20 or fewer beds that offers a full range of hospice services within its walls.		able to receive hospice care in a facility of 20 or fewer beds that offers a full range of hospice services within its walls. The facility would not be required to offer services outside of the home and the limit on the aggregate number of inpatient days provided to Medicare beneficiaries who elect hospice care would be waived.

Other Part A Provisions

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Make grants to States and certain rural hospitals. The Secretary is able to make grants for specified purposes to States or eligible small rural hospitals that apply for such awards under the Medicare Hospital Flexibility Program. The Secretary may also award grants to hospitals to assist eligible small rural hospitals (with less than 50 beds) in implementing data systems required under BBA 1997. Annual funding for the Rural Hospital Flexibility Grant Program was \$25 million from 1999 through 2001; \$40 million in FY2002; and \$25 million in 2003. The authorization to award the grants expired in FY2002.	Section 405(f). The rural hospital flexibility grant program is authorized at \$35 million each year from FY2005 through FY2008. Starting in FY2005, a state is required to consult with the hospital association and rural hospitals in the state on the most appropriate way to use such funds. A state may not spend more than the lesser of 15% of the grant amount or the States' federally negotiated indirect rate for administrative purposes. Beginning with FY2005, up to 5% of the total amount appropriated for grants will be available to the Health Resources and Services Administration for administering these grants.	Section 405(f). Under this program, the Secretary would be able to award grants of up to \$50,000 to hospitals to assist eligible small rural hospitals in reducing medical errors and increasing patient safety under the new Small Rural Hospital Improvement Program. Appropriations of \$25 million each year from the Treasury from FY2004 through FY2008 would be authorized for this purpose. Appropriations of \$40 million each year from FY2004 through FY2008 from the HI Trust Fund for grants to states for specified purposes would be authorized. States that are awarded grants would be required to consult with the hospital associations and rural hospitals in the state.	Section 405(g). The authorization to award grants under the existing Rural Hospital Flexibility Program would be established from FY2004 through FY2008 from the Federal HI Trust Fund at amounts of up \$25 million each year.
Establish health care infrastructure loan program. No provision in current law.	Section 1016. A loan program will be established to improve the cancer-related health care infrastructure. In order to receive assistance, the applicant will be required to: (1) be engaged in cancer research; and (2) be designated as a cancer center for the National Cancer Institute (NCI) or be similarly designated by the state. \$200 million in budget authority is authorized for July 1, 2004 through FY2008 to carry out the loan program, \$2 million for	Section 608. A loan program would be established to improve the cancer-related health care infrastructure in states with a population of less than 3 million. In order to receive assistance, the applicant would be required to: (1) be engaged in cancer research; and (2) be designated as a cancer center for the NCI or be similarly designated by the state. \$49 million in budget authority would be authorized for July 1, 2004 through	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
	program administration. By 4 years from enactment, the Secretary will submit a report to Congress on continuing the program.	FY2008 to carry out the loan program, \$2 million for program administration.	
Establish capital infrastructure revolving loan program The Public Health Services Act establishes a fund in the Treasury from which the Secretary of HHS can make loans or loan guarantees in the amounts that have been specified in appropriations acts from time to time. Under the Medicare Rural Hospital Flexibility Program established as part of Title XVIII, the Secretary may award grants to rural hospitals to cover the implementation costs associated with data systems needed to meet the BBA 97 requirements.	No provision.	Section 609. The Secretary would be able to make loans to any rural entity including rural health clinics, a medical facility with less than 50 beds in non- MSA counties or in rural census tracts of MSAs, rural referral centers or sole community hospitals for various purposes. An geographically reclassified entity would be eligible for these loans and loan guarantees. The government's total exposure for this program would not exceed \$50 million per year and the principal amount of all loans directly made or guaranteed in any year is not to exceed \$250 million per year. In addition, rural providers could apply to receive \$50,000 planning grants to help assess capital and infrastructure needs. The grants awarded in any year would not exceed \$2.5 million. The program would expire after September 30, 2008.	No provision.
Establish rural community hospital demonstration program. No provision in current law.	Section 410A. The Secretary will establish a 5-year rural community hospital (RCH) demonstration program in selected rural areas with low population densities. Under the program, up to 15 hospitals with 50 acute care beds will receive payment for inpatient services either on the basis of its reasonable costs (without regard to the amount of customary charges) or using a target amount. The project will be implemented not later than January 1, 2005 and not before October 1, 2004. The project would be budget neutral. Certain limits on beneficiary cost-sharing will be imposed. The Secretary will submit a report with recommendations to Congress no later than 6 months after completion of the project	Section 414. The Secretary would be required to establish a 5-year RCH demonstration program in 4 areas including Kansas and Nebraska to pay for acute inpatient services, outpatient services, and certain home health services in qualifying hospitals either on the basis of its reasonable costs (without regard to the amount of customary charges) or using the respective prospective payment systems for those services. In this instance, reasonable cost reimbursement of capital costs would include a return on equity payment of 150% of the average rate of interest paid by the HI Trust Fund. The project would be budget neutral. Certain limits on beneficiary cost-sharing would be imposed.	No provision.
Ensure status as long-term hospitals for certain hospital-in-hospitals. A hospital-in-	No provision.	Section 416. The Secretary would not be able to impose any special conditions on the	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>a-hospital is a long-term care hospital that is physically located in an acute care hospital. CMS has established certain requirements for these entities to be excluded from the IPPS and be paid as a long-term hospital. It exempted existing entities (those that were in existence on or before September 30, 1995) when these requirements were established. On May 19, 2003, CMS proposed that a grandfathered hospital-in-a hospital would only be exempt from the existing requirements if it continues to operate within the same terms and conditions that were in effect as of September 30, 1995.</p>		<p>operation, size, number of beds, or location of an existing long-term hospital in order to continue participating in Medicare or Medicaid or to continue being classified as a long-term hospital. The Secretary would not be able to adopt a proposed regulation that would implement such conditions or any revision to such regulation that have a comparable effect. [Duplicate provision is at Section 420B]</p>	
<p>Establish special treatment for certain entities. Unlike other providers, acute hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification from a rural area to an urban area, or reassignment from one urban area to another urban area. Hospital reclassifications are established on a budget neutral basis so aggregate inpatient prospective payment system expenditures will not increase as a result. Aside from reclassifications through the MGCRB, hospitals have also been reclassified by law.</p>	<p>Section 508(f). Reclassifications of a county or area made by an Act of Congress that expired on September 30, 2003 shall be reinstated starting on January 1, 2004 through September 30, 2004.</p>	<p>Section 417. Starting October 1, 2003, Iredell County and Rowan County, North Carolina would be deemed to be located in the Charlotte-Gastonia-Rock Hill, NC-SC Metropolitan Statistical Area for the purpose of Medicare's inpatient and outpatient acute hospital payments as well as SNF and home health payments. The Secretary would be required to adjust the wage index values of all hospitals in North Carolina to assure that aggregate payments for hospital inpatient operating costs are not greater than they would have been without such a change; also aggregate payments for SNF and home health services in North Carolina would not be greater than they would have been without such a change.</p>	<p>No provision.</p>
<p>Limit charges for contract health services provided to Indians by participating hospitals. The Indian Health Service (IHS) provides health care both directly, through tribes and tribal consortia, and through urban Indian organizations.</p>	<p>Section 506. Hospitals that participate in Medicare and that provide Medicare covered inpatient hospital services under the contract health services program funded by the Indian Health Services and operated by the Indian Health Service, an Indian tribe, an Indian tribal organization, or an urban Indian organization will be paid in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodologies,</p>	<p>Section 412. The amendment would prohibit Medicare providers from charging the Indian Health Service more than the Medicare-established rates for inpatient hospital services.</p>	<p>No provision.</p>

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	and rates of payments. This will include the requirement to accept these rates as payment in full except for the payment rates for neonatal care. This provision will apply to Medicare participation agreements in effect or entered into by a date specified by the Secretary. In no case will this date be later than 1 year after the date of enactment.		
Pay interest on clerical error into HI Trust Fund. An incorrect amount of income was transferred into the HI Trust Fund in April 2001, because of a clerical error. An additional amount was transferred into the HI Trust Fund in December, 2001 to correct for the principal amount associated with the error. Correction of the interest associated with the clerical error requires legislation.	Section 734. The Secretary of the Treasury is required to transfer into the HI Trust Fund an amount that would have been held by that fund if the clerical error had not occurred. The appropriation is to be made and transfer is required within 120 days of enactment of this Act. In the case of a clerical error that occurs after April 15, 2001, the Secretary of the Treasury is required to notify the appropriate committees of Congress about the error and the actions to be taken, before such action is taken.	Section 623. After consultation with the Secretary of HHS, the Secretary of the Treasury would be required to transfer into the HI Trust fund an amount that would have been held by that fund if the clerical error had not occurred within 120 days of enactment.	Section 513. Same provision.
Apply the Occupational Safety and Health Act of 1970 (OSHA) bloodborne pathogens standard to public hospitals. Section 1866 of the Social Security Act establishes certain conditions of participation that hospitals must meet in order to participate in Medicare.	Section 947. Public hospitals, not otherwise subject to the Occupational Safety and Health Act of 1970, are required to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations. A hospital that fails to comply with the requirement will be subject to a civil monetary penalty, but cannot be terminated from participating in Medicare. The provision applies to hospitals as of July 1, 2004.	No provision.	Section 947. As of July 1, 2004, public hospitals that are not otherwise subject to OSHA would be required to comply with the Bloodborne Pathogens standard under Section 1910.1030 of Title 29 of the <i>Code of Federal Regulations</i> . A hospital that fails to comply with the requirement would be subject to a civil monetary penalty, but would not be terminated from participating in Medicare.

Provisions Relating to Part B

Physician and Practitioner Services

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Establish floor on geographic adjustment for physician fee schedule. Medicare's payment for physicians' services	Section 412. The Secretary is required to increase the value of any work geographic index that is below 1.0 to	Section 421. For services furnished after January 1, 2004, the Secretary would be required to increase the value	Section 605(a). For services furnished after January 1, 2004 and before January 1, 2006, the Secretary

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>under a fee schedule has three components: the relative value for the service, geographic adjustment factors and a conversion factor into a dollar amount. The geographic adjustment factors are indices that reflect the relative cost difference in a given area in comparison to the national average</p>	<p>1.0 for services furnished on or after January 1, 2004 and before January 1, 2007</p>	<p>of any work geographic index that is below .980 to .980. The values for work index would be raised to 1.0 for services furnished in 2005, 2006, and 2007. The practice expense and malpractice geographic indices in low value localities areas would be raised to 1.00 for services furnished in 2005 until 2008.</p>	<p>would be required to increase the value of any work geographic index that is below 1.00. to 1.00 unless the Secretary determines, based on the subsequent GAO study which is due by September 1, 2004, that there is no sound economic rationale for such change.</p>
<p>Increase practice expense payments for certain specialists. The relative value associated with a particular physician service is the sum of three components one of which is practice expense. Practice expense includes both direct costs (such as a clinician's time and the medical supplies to provide a specific service to a patient) and indirect costs (such as rent and utilities). BBRA required the Secretary to establish a data collection process and standards for determining practice expense relative values as well as to use data collected or developed outside HHS, to the maximum extent practicable, consistent with sound data collection practices. The relative values are periodically reviewed and adjusted to account for various factors; changes that cause more than \$20 million in spending trigger a budget neutrality adjustment.</p>	<p>Sections 303(a) and 304. Beginning in 2004, the practice expense relative value units for oncology administration services will be adjusted using survey data that was collected as of January 1, 2003 (this data was submitted by the American Society of Clinical Oncologists); the additional expenditures will be exempt from the budget neutrality requirement in 2004. The work relative value units for drug administration services furnished on or after January 1, 2004 will be equal to the work relative value units for a level 1 office medical visit for an established patient. Starting in 2005 through 2006, the practice expense relative values for other drug administration services will be increased in the physician fee schedule using appropriate supplemental survey data submitted by March 1, 2004, for 2005, or March 1, 2005 for 2006. Data will be accepted from those specialists who received 40% or more of their Medicare payments in 2002 from drugs and biologicals. The existing drug administration codes will be evaluated under existing processes after consultation with interested parties. These adjustments in practice expense relative value units for certain drug administration services are exempt from the budget neutrality requirements in 2005, 2006, and 2007. The Secretary can adjust practice expense payments in subsequent years, subject to the budget neutrality provisions. The effect of the nonphysician workpool methodology will not be changed. Medicare's payment policy in effect on October 1, 2003, for the administration of more than one drug or biological to an individual on a single day through the push technique will be modified and the increased payments will be exempt from the budget-neutrality requirement in 2004. A transitional</p>	<p>Section 432(b)(1). The Secretary would establish the practice expense relative values for the CY2004 fee schedule using the survey data from a physician specialty group as of January 1, 2003 if the data appropriately covers the practice expenses for oncology administration services. The Secretary would review and appropriately modify payments for the administration of more than one anti-cancer agent to a patient in a day. The resulting increase in spending would be exempt from the budget neutrality requirement. Also, the Secretary would change the non-physician work pool method so that associated payments are not inordinately reduced. These adjustments would not be implemented unless other outpatient drug pricing changes in the section are implemented.</p>	<p>Section 303(a) The Secretary would increase the practice expense relative values for the physician fee schedule in CY2005 using appropriate survey data on the expenses associated with drug administration provided by entities and organizations that are submitted by December 31, 2004. Using existing processes for coding considerations, the Secretary would evaluate existing codes for drug administration to ensure accurate reporting and billing for these services. Any resulting CY2005 payment increase would not be subject to budget neutrality provisions, would be exempt from administrative and judicial review, and would be treated as a change in law and regulation in the sustainable growth rate determination. Subsequent budget neutrality adjustments would be permitted. The same non-physician work pool methodology provision as in S. 1 is included.</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
	adjustment (or additional payment) of 32% in 2004 and 3% in 2005 will be made.		
Increase payments to physicians in newly created scarcity areas; change Medicare Incentive Program (MIP). Physicians providing services in a health professional shortage area (HPSA) are entitled to an incentive payment from the Medicare program. This incentive payment is a 10% increase over the amount which would otherwise be paid under the physician fee schedule.	Section 413. Certain physicians, both primary care and specialists, in scarcity areas are eligible for an additional 5% increase in payments starting on January 1, 2005 and ending by January 1, 2008. To determine the scarcity areas, the Secretary will calculate ratios of practicing primary care physicians and specialists to Medicare beneficiaries, rank each county (or equivalent area) according to each ratio, and then identify those areas with the lowest ratios which collectively represent 20% of the total Medicare beneficiary population in those areas. The list of counties will be revised no less often than once every 3 years unless there are no new data. There will be no administrative or judicial review of the designation of the county or area as a scarcity area, the designation of an individual physician's specialty, or the assignment of a postal zip code to the county or other area. MIP payments to physicians in HPSAs that consist of entire counties will be made without requiring the physician to identify the HPSA when requesting payment.	Section 422. The Secretary would be required to establish procedures to determine when a physician in a HPSA is eligible for a bonus payment. The Secretary would also be required to establish an ongoing education program, an ongoing study and submit annual reports. A GAO report would be required no later than 1 year from enactment.	Section 417. Same provision with respect to Secretary developing procedures to identify physicians eligible for bonus payments. Also, physicians in newly-created scarcity areas as well as other physicians would be eligible for an additional 5% increase in their fee schedule payment amounts. The Secretary would also be required to publish a list of all areas that qualify as a HPSA each year in the proposed and final rule implementing the physician fee schedule.
Revise reassignment provisions. Beneficiaries are the parties who are entitled to receive Medicare payments under the Medicare statute. However, most beneficiaries assign these rights to participating physicians, suppliers, and other providers who directly provide the care and then submit claims for Medicare payment. Although Medicare permits physicians to reassign their right to payment to certain other entities, they cannot reassign their right to payment to staffing companies (entities that retain physicians on a contractual basis).	Section 952. The bill permits Medicare payment for Part B services to be made to an entity, as defined by the Secretary, that has a contractual arrangement with the physician or other person who provided the service. In order to bill for the service, the entity and the contractual arrangement will have to meet program integrity and other safeguards specified by the Secretary.	Section 434. Staffing companies (individuals or entities) would be able to submit claims to Medicare for physician services provided under contractual arrangement between the company and the physician, if the arrangement meets appropriate program integrity and other safeguards established by the Secretary.	Section 952. Same provision with some drafting differences.
Extend provision for separate payments of certain inpatient pathology services. In general, independent laboratories cannot directly bill for the technical component of pathology services provided to Medicare beneficiaries who are inpatients or outpatients	Section 732. Direct payments for the technical component for these pathology services will be made for services furnished during 2005 and 2006.	Section 435. Direct payments for the technical component for these pathology services would be made for services furnished during 2005.	Section 734. Similar provision except Medicare would make direct payments for the technical component of pathology services from 2004 through 2008. Would also specify that a change

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
of acute care hospitals. BIPA permitted certain independent laboratories with existing arrangements with acute hospitals to do so if the arrangement had been in effect as of July 22, 1999. The direct payments for these services apply to services furnished during a 2-year period starting on January 1, 2001 and ending December 31, 2002.			in hospital ownership would not affect these direct billing arrangements.
Increase Medicare payments to physicians in Alaska. Physicians that provide services to Medicare beneficiaries are paid based on Medicare's physician fee schedule that is adjusted to account for geographic variations in practice expenses.	Section 602. Physicians in Alaska with values of practice expense, malpractice, and work geographic index below 1.67 will have these values raised to 1.67 starting January 1, 2004 and before January 1, 2006.	Section 450K. For 2004, physicians in Alaska would be paid 90% of the VA physician fee schedule used for FY2001. In 2005, this amount would be increased by the update amount for the Medicare physician fee schedule for 2005. If no VA fee schedule amount exists for a service, the payment amount would be an adjustment to the Medicare payment. The adjustment would equal 90% of the overall percentage difference between the two fee schedules weighted by the distribution of Medicare claims in 2001.	No provision.
Establish update to physician fee schedule. Medicare pays for services of physicians and certain non-physician practitioners on the basis of a fee schedule. The law provides a specific formula for calculating the annual update to the conversion factor.	Section 601. The update to the conversion factor for 2004 and 2005 will not be less than 1.5% and will be exempt from the budget neutrality adjustment.	No provision.	Section 601. The update to the conversion factor for 2004 and 2005 would be not less than 1.5% and would be exempt from the budget neutrality adjustment.
Change the sustainable growth rate formula. Medicare pays for services of physicians and certain non-physician practitioners on the basis of a fee schedule. The law provides a specific formula for calculating the annual update to the conversion factor which regulates overall spending for physicians' services. Several factors enter into the calculation of the formula. One of those factors is the sustainable growth rate (SGR) which is essentially a target for Medicare spending growth in physicians' services. One measure	Section 601. The formula for calculating the sustainable growth rate will be modified. Starting in 2003, the GDP factor will be based on the annual average change over the preceding 10 years (a 10-year rolling average). The 10-year rolling average calculation of the GDP will apply to computations of the SGR starting in 2003.	Section 464. The provision expresses a sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not prevent cuts in 2004 and following years that stem from the SGR formula. [Duplicate of Section 622]	Section 601. The formula for calculating the sustainable growth rate would be modified. Starting with the SGR for 2003, the GDP factor would be based on the annual average change over the preceding 10 years (a 10-year rolling average). This calculation would replace the current GDP factor which measures the 1-year change from the preceding year.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
used to calculate the SGR is the annual percentage change in gross domestic product (GDP). If expenditures exceed the target, the update for a future year is reduced. If expenditures are less than the target, the update is increased. The recent negative update adjustment factors reflect the application of the SGR system.		Section 629. The provision provides a sense of the Senate that the reductions in Medicare's physician fee schedule are destabilizing, primarily caused by the sustainable growth rate calculation, and that CMS should use its discretion to make certain exclusions and adjustments to the SGR calculation.	
Require GAO report on physician compensation. No provision in current law.	No provision.	No provision.	Section 953(a). No later than six months from enactment, GAO would report to Congress on the appropriateness of the conversion factor updates and the SGR formula for 2002 and subsequently; the stability and the predictability of the updates; and alternatives to the SGR in the update. No later than 12 months from enactment, GAO would be required to report to Congress on all aspects of physician compensation for Medicare services. The report would review alternatives to the physician fee schedule.
Extend Medicare's private contracting authority to dentists and podiatrists. Private contracting allows a physician and Medicare beneficiary not to submit a claim for a service which would otherwise be covered and paid for by Medicare. Under private contracting, physicians (not podiatrists or dentists) can bill patients at their discretion without being subject to upper payment limits specified by Medicare. If a physician decides to enter a private contract with a Medicare beneficiary, that physician must agree to forego any reimbursement by Medicare for all Medicare beneficiaries for 2 years.	Section 603. Doctors of dental surgery or of dental medicine, doctors of podiatric medicine, and doctors of optometry will be able to enter into private contracts with Medicare beneficiaries. The provision will be effective upon enactment.	No provision.	Section 604. Doctors of dental surgery or of dental medicine and doctors of podiatric medicine would be able to enter into private contracts with Medicare beneficiaries.
Require GAO report on geographic differences in physician payments. No provision in current law.	Section 413(c). GAO will study payment differences under the physician fee schedule for different geographic areas. The study, including recommendations concerning use of more current data and use of cost data rather	Section 444. GAO would be required to study geographic differences in payment amounts in the physician fee	Section 413. Same provision.

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	than price proxies, is due to Congress within 1 year of the enactment date.	schedule and report to Congress within 1 year of enactment.	
Require GAO report on beneficiary access to services including concierge care and impact of these mandatory fees and/or services on access. Periodic analyses by the Physician Payment Review Commission, and subsequently MedPAC, as well as CMS showed that access to physicians' services generally remained good for most beneficiaries through 1999. More recent surveys convey a more mixed picture however.	<p>Section 604. GAO is required to conduct a study on access of Medicare beneficiaries to physicians' services under Medicare and submit a report to Congress on this study within 18 months of enactment.</p> <p>Section 650. GAO would study concierge care provided to Medicare beneficiaries and its effect on their access to Medicare covered services and submit a report to Congress, including recommendations, no later than 12 months from enactment.</p>	Section 447. GAO would submit a report to Congress, including recommendations, regarding the effect of concierge care on beneficiaries' access to Medicare covered services by 12 months from enactment. In this instance, concierge care would be an arrangement where a physician or practitioner charges an individual a membership fee or other fee or requires the purchase of an item or service as a prerequisite for providing the care.	Section 602(a). GAO would be required to conduct a study on access of Medicare beneficiaries to physicians' services under Medicare including beneficiaries' use of services through an analysis of claims data and the extent to which physicians are not accepting new Medicare beneficiaries as patients.
Require Institute of Medicine (IOM) study on supply of physicians. No provision in current law.	No provision.	No provision.	Section 602(b). The Secretary would be required to request that IOM study the adequacy of the supply of physicians (including specialists) in the country and the factors that affect supply. The Secretary would be required to submit the results of the study in a report to Congress no later than 2 years from the date of enactment.
Require MedPAC report on payment for physician services. No provision in current law.	<p>Section 303(a). MedPAC is required to review the payment changes as they affect payments for items and services furnished by oncologists and for drug administration services furnished by other specialists and submit a report to the Secretary. The MedPAC report on oncologists' payments is due to Congress by January 1, 2006 and the report on drug administration services furnished by other specialists is due by January 1, 2007. The Secretary could make appropriate adjustments to payments as part of the rulemaking for physician payments for 2006.</p> <p>Section 606. MedPAC is required to report to Congress on the effects of refinements to the practice expense component, by specialty within 1 year of enactment. A MedPAC report on the effect of increased physician services on the well-being of Medicare</p>	No provision.	Section 603. MedPAC would be required to report to Congress on the effects of refinements to the practice expense component of payments for physicians' services after full implementation of the resource-based payment in 2002.

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	beneficiaries and other factors is due within 1 year of enactment as well.		
Require consultative process before establishing new evaluation and management (E&M) codes. Initial E&M documentation guidelines were issued in 1995 with revisions issued in 1997; both remain in force today. Approximately 40% of Medicare payments for physician services are for services which are classified as evaluation and management services (i.e., physician visits). The Secretary stopped work on the current re-draft of E&M codes in order to reassess the entire effort.	Section 941. The Secretary is prohibited from implementing new E&M documentation guidelines unless the Secretary developed the guidelines in collaboration with practicing physicians, established a plan with goals, conducted pilot projects, and established and implemented an education program on the use of the guidelines with appropriate outreach. Any changes to E&M guidelines are required to reduce paperwork burden on physicians.	Section 553. The Secretary, before making changes in documentation guidelines for, providing clinical examples of, or changing codes for reporting E&M physician services, would be required to ensure that the process used in developing the guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.	Section 941. The Secretary would be prohibited from implementing new E&M documentation guidelines unless the Secretary developed the guidelines in collaboration with practicing physicians; established a plan with goals; conducted pilot projects; established and implemented an education program on the use of the guidelines with appropriate outreach. Changes to E&M guidelines would be required to reduce paperwork burden on physicians.
Pay for additional hospital outpatient department (HOPD) mammography services using physician fee schedule. Screening mammography coverage includes the radiological procedure as well as the physician's interpretation of the results of the procedure. The usual Part B deductible is waived for tests. Payment is made under the physician fee schedule. Certain services paid under fee schedules or other payment systems are excluded from Medicare's OPPS-PPS. For diagnostic mammography services provided in an HOPD, the technical component of the fee is paid under the HOPD PPS.	Section 614. Screening mammography and diagnostic mammography will be excluded from OPPS. This provision will apply to screening mammography services furnished on or after the date of enactment and will apply to diagnostic mammography services furnished on or after January 1, 2005.	Section 445. Unilateral and bilateral diagnostic mammography as well as screening mammography services would be paid for under the physician fee schedule beginning January 1, 2005.	Section 614. Same provision except effective date would be January 1, 2004.
Pay the physician for pharmacy management services. No provision in current law.	Section 303(e)(2). The Secretary will pay a dispensing fee (less the applicable deductible and coinsurance amounts) to licensed approved pharmacies for covered immunosuppressive drugs, oral anti-cancer drugs, and oral anti-nausea drugs used as part of a chemotherapeutic regimen.	No provision.	Section 303(g). The Secretary would be required to provide for separate payments in the physician fee schedule to cover the administration and acquisition costs associated with covered drugs and biologicals furnished by a contractor under the competitive acquisition program.

Hospital Outpatient Department (HOPD), Ambulatory Surgery Center (ASC), and Clinic Services

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Hospital Outpatient Department (HOPD) Services			
Extend hold-harmless provisions for small rural hospitals. The outpatient prospective payment system (OPPS) was implemented in August 2000 for most acute care hospitals. Under hold-harmless provisions, rural hospitals with no more than 100 beds are paid no less under this PPS system than they would have received under the prior reimbursement system for covered HOPD services provided before January 1, 2004.	Section 411. The hold-harmless provisions governing OPPS for small rural hospitals are extended to HOPD services provided before January 1, 2006. The Secretary is required to conduct a study to determine if the costs, by ambulatory payment classification (APC) groups, incurred by rural providers exceed those costs incurred by urban providers. If appropriate, the Secretary will provide for a payment adjustment to reflect the higher costs of rural providers by January 1, 2006	Section 423. The hold-harmless provisions governing OPPS reimbursement for small rural hospitals would be re-established in 2006.	Section 407. The hold-harmless provision would be extended to January 1, 2006. The Secretary would be required to conduct a study to determine if the costs by ambulatory payment classification (APC) groups incurred by rural providers exceeds those costs incurred by urban providers and provide an appropriate payment adjustment to reflect the higher costs of rural providers by January 1, 2005.
Establish hold-harmless provision for sole community hospitals (SCHs). No provision in current law.	Section 411. The hold harmless provisions are extended to SCHs located in a rural area starting for cost reporting periods beginning on and after January 1, 2004 and ending for HOPD services furnished before January 1, 2006.	Section 423. OPPS hold-harmless provisions would be extended to SCHs located in rural areas for services provided in 2006.	Section 407. The hold-harmless provisions would be extended to SCHs for 2004 and 2005.
Change hold-harmless provision for children's hospitals. OPPS contains a permanent hold-harmless for cancer hospitals and children's hospitals where payments to these hospitals cannot fall below what these hospitals would have received under the payment system in place before OPPS.	No provision.	Section 450J. These provisions for children's hospitals would be modified so that those in Maryland (which has a Medicare waiver) that are paid less under OPPS than what would have been received under the prior system or using hospital's reasonable operating and capital costs receive additional payments after October 1, 2003.	No provision.
Increase HOPD payments to small rural hospitals. Under OPPS, which was implemented in August, 2000, Medicare pays for covered services using a fee schedule based on APCs. Beneficiary copayments are established as a percentage of Medicare's fee schedule payment and differ by APC. Certain hospitals, including rural hospitals with no more than 100 beds, are protected, either on a temporary or on a permanent basis, from financial losses that result from	No provision.	Section 424. Medicare's fee schedule payments would be increased by 5% for covered outpatient clinic and emergency room visits that are provided by rural hospitals with up to 100 beds beginning January 1, 2005 and before January 1, 2008. Beneficiary copayment amounts would not be affected. The increased Medicare payments would not be considered when calculating a rural hospital's hold-harmless payment. Budget neutrality provisions for	No provision.

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implementation of OPPTS under hold-harmless provisions		Medicare's OPPTS would not apply. Finally, these increased payments would not affect Medicare payments for covered outpatient services after January 1, 2008.	
Increase payments to sole community hospitals (SCHs) for clinical diagnostic laboratory tests. Generally, hospitals that provide clinical diagnostic laboratory tests under Part B are reimbursed using a fee schedule. SCHs that provide some clinical diagnostic tests 24 hours a day qualify for a 2% increase in the amounts established in the outpatient laboratory fee schedule; no beneficiary cost-sharing amounts are imposed.	No provision.	Section 427. SCHs that provide clinical diagnostic laboratory tests covered under Part B in 2005 and 2006 would be reimbursed their reasonable costs of furnishing the tests. No beneficiary cost-sharing amounts would apply to these services.	No provision.
Establish new payment method for certain HOPD drugs and biologicals. Under OPPTS, Medicare pays for covered outpatient drugs in one of three ways: (1) as a transitional pass-through payment; (2) as a separate APC payment; or (3) as packaged APC payment with other services. Transitional pass-through payments are extra payments to cover the incremental cost associated with certain medical devices, drugs and biologicals that are inputs to an existing service. The additional payment for a given item is established for 2 or 3 years and then the costs are incorporated into the APC relative weights. BBRA specified that pass-through payments would be made for current orphan drugs; current cancer therapy drugs, biologicals, and brachytherapy; current radiopharmaceutical drugs and biological products; and new drugs and biological agents. Generally, CMS has established that a pass-through payment for an eligible drug is based on the difference between 95% of its average wholesale price and the portion of the otherwise applicable APC payment rate attributable to the existing drug, subject to a budget neutrality provision.	Section 621. Starting January 1, 2004, specified covered HOPD drugs will be paid based on a percentage of the reference average wholesale price for the drug. The percentage of the reference price for sole-source drugs manufactured by one entity can be no less than 88% and no greater than 95% in CY2004 and no less than 83% and no greater than 95% in CY2005. The percentage of the reference price for innovator multiple source drugs can be no greater than 68% in CY2004 and CY2005. The percentage of the reference price for noninnovator multiple source drugs can be no greater than 46% in CY2004 and CY2005. The reference average wholesale price is the average wholesale price for the drug as of May 1, 2003. In subsequent years, payment will equal to the average acquisition cost for the drug for that year (which may vary by hospital group taking into account hospital volume or other hospital characteristics) or if hospital acquisition cost data are not available, the average price for the drug in the year established under Sections 1842(o), 1847A or 1847B (which specify Medicare payments for outpatient drugs covered under Part B)	Section 436. A new payment method for certain HOPD drugs and biologicals would be established for 2005 and 2006. The drugs and biologicals would be those for which hospitals received transitional pass-through payments prior to January 1, 2005 that have been assigned to drug-specific APCs beginning the date of enactment. Or those that would have been paid in such a manner but for the application of this provision. Payments made under this provision would be exempt from the budget neutrality requirement in FY2005 and FY2006. In 2005, these drugs would be paid as follows: a single source or orphan product would be paid at 94% of the AWP existing on May 1, 2003; a multiple source drug would be paid at 91% of that existing average wholesale price (AWP); and a drug with generic versions would be paid at 71% of that existing AWP. Those items furnished as part of other HOPD services would be paid using the same applicable percentage of the AWP that would have been determined on May 1, 2003 if such payment were to have been made on that date. For 2006, these payment amounts	Section 621(a). Starting for services furnished beginning January 1, 2004, certain covered HOPD drugs would be paid no more than 95% of AWP or less than the transition percentage of the AWP from CY2004 through CY2006. In subsequent years, payment would be equal to average price for the drug in the area and year established by the competitive acquisition program under 1847A. The covered HOPD drugs affected by this provision are radiopharmaceuticals and outpatient drugs that were paid on a pass-through basis on or before December 31, 2002. These would not include drugs for which pass-through payments are first made beginning January 1, 2003 or those drugs for which a temporary HCPCS code has not been assigned. Drugs for which a temporary HCPCS code has not been assigned would be reimbursed at 95% of the AWP. The transition percentage to AWP for sole-source drugs manufactured by one entity is 83% in CY2004, 77% in CY2005, and 71% in CY2006. The transition percentage to AWP for innovator multiple source drugs is 81.5% in CY2004, 75% in CY2005, and 68% in CY2006. The transition percentage to AWP for multiple source drugs with generic drug competitors is 46% in

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	<p>as calculated and adjusted by the Secretary. The covered HOPD drugs affected by this provision are outpatient drugs that were paid on a pass-through basis on or before December 31, 2002. These would not include drugs for which pass-through payments are first made on or after January 1, 2003; those drugs for which a temporary HCPCS code has not been assigned; or, during 2004 and 2005, orphan drugs. Drugs for which a temporary HCPCS code has not been assigned will be reimbursed at 95% of the AWP. Orphan drugs during this 2-year time period will be paid at an amount specified by the Secretary.</p> <p>MedPAC will submit a report to the Secretary on the payment adjustment to ambulatory payment classifications for specified covered outpatient drugs that takes into account overhead and related expenses (such as pharmacy services and handling costs). The Secretary is authorized to adjust the weights for ambulatory payment classification based on such a recommendation. The additional expenditures that result from the previous changes will not be taken into account in establishing the conversion, weighting and other adjustment factors for 2004 and 2005, but will be taken into account in subsequent years.</p> <p>For drugs and biologicals furnished in 2005 and 2006, the Secretary is required to lower the threshold for establishing a separate APC group for higher cost drugs from \$150 to \$50 per administration. These separate drug APC groups are not eligible for outlier payments. Starting in CY2004, Medicare's transitional pass-through payments for drugs and biologicals covered under a competitive acquisition contract will equal the average price for the drug or biological for all</p>	<p>would be increased by CPI-U. A private non-profit organization under contract would determine the hospital acquisition, pharmacy services, and handling costs for each of the drugs paid in this fashion to set payments in 2007 and beyond. This analysis would be accurate within 3% of the true mean hospital acquisition and handling costs at a 95% confidence level; begin by January 1, 2005; and be updated annually. Starting January 1, 2006, a report would be due to Congress each year.</p>	<p>CY2004 through CY2006. The additional expenditures resulting from these provisions would not be subject to the budget neutrality requirement. Starting in CY2004, the Secretary would be required to lower the threshold for establishing a separate APC group for higher costs drugs from \$150 to \$50 per administration. These separate drug APC groups would not be eligible for outlier payments. Starting in CY2004, Medicare's transitional pass-through payments for drugs and biologicals covered under a competitive acquisition contract would reflect the amount paid under that contract, not 95% of AWP.</p>

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	competitive acquisition areas calculated and adjusted by the Secretary for that year.		
Limit application of functional equivalence standards when determining a drug's eligibility for transitional pass through payments. Starting in 2003, CMS decided that a new anemia treatment for cancer patients was no longer eligible for pass-through payments under OPPS, because it was functionally equivalent (although not structurally identical or therapeutically equivalent) to an existing treatment. The transitional pass-through rate for the drug was reduced to zero starting for services in 2003.	Section 622. The Secretary is prohibited from publishing regulations that apply a functional equivalence standard to a drug or biological for transitional pass-through payments under OPPS. This prohibition applies to the application of the functional equivalence standard on or after the date of enactment, unless such application was made prior to enactment and the Secretary applies such standard to the drug only for the purposes of transitional pass-through payments. This provision does not affect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of the Food and Drug Administration.	Section 437. The Secretary would not be able to apply this standard to a drug or biological for transitional pass-through payments under OPPS. This prohibition would apply, unless such a standard was made prior to enactment and only for the purposes of transitional pass-through payments. The Secretary would still be able to deem a particular drug as identical to another drug if the two products are pharmaceutically equivalent and bioequivalent, as determined by FDA.	Section 621(c). The Secretary would be prohibited from applying a "functional equivalence" standard or any similar standard in order to deem a particular drug or biological to be similar or functionally equivalent to another drug unless the Commissioner of FDA establishes such a standard and certifies that the two products are functionally equivalent. The Secretary would be able to implement this standard after meeting applicable rulemaking requirements. The provision prohibits the application of this standard to a drug or biological prior to June 13, 2003.
Establish separate payments for certain brachytherapy devices. In Medicare's OPPS, current drugs and biologicals that were eligible for transitional pass-through payments on or prior to January 1, 2000, were removed from that payment status effective January 1, 2003. CMS established separate APC payments for certain of these drugs. Other drugs such as brachytherapy seeds (radioactive isotopes used in cancer treatments) were packaged into payments for brachytherapy procedures.	Section 421(b). From January 1, 2004 through December 31, 2006, Medicare's payments for brachytherapy devices will equal the hospital's charges adjusted to cost. Charges for such devices will not be included in determining any outlier payments. The Secretary is required to create separate APCs to pay for these devices that reflect the number, isotope, and radioactive intensity of such devices, including separate groups for palladium-103 and iodine-125 devices. GAO is required to study the appropriateness of payments for brachytherapy devices and submit a report including recommendations to Congress and to the Secretary no later than January 1, 2005.	Section 450A. The Secretary would be required to conduct a budget neutral, 3-year demonstration project that would exclude brachytherapy devices from the OPPS and make payment on the basis of the hospital's charges for each device, adjusted to cost. The Secretary would be required to create separate, additional groups of covered HOPD services for brachytherapy devices to reflect the number, isotope, and radioactive intensity of such devices.	Section 621(b). From 2004 through 2006, payments for brachytherapy devices would equal the hospital's charges adjusted to cost. The Secretary would be required to create separate APCs to pay for these devices that reflect the number, isotope, and radioactive intensity of such devices. This would include separate groups for palladium-103 and iodine-125 devices. GAO would submit a report to Congress on the appropriateness of such payments no later than January 1, 2005.
Require hospital acquisition study. No provision in current law	Section 621(a). GAO will conduct an acquisition cost survey for each specified covered drug in 2004 and 2005. No later than April 1, 2005, GAO will furnish this	No provision.	Section 621(d). The Secretary would study the hospital acquisition costs related to covered outpatient drugs that cost \$50 per

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	survey data to set 2006 payment rates. GAO will submit a report to Congress on 2006 rates no later than 30 days after issuance of the proposed rule setting forth these rates. GAO will submit recommendations regarding the survey methodology and frequency to the Secretary who will conduct periodic surveys to set subsequent payment rates.		administration and more that are reimbursed under the OPFS.
Ambulatory Surgery Center Services (ASCs)			
Reduce ambulatory surgery center (ASC) update. Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ASC. From FY1998 through FY2002, the update was established as the CPI-U minus 2.0 percentage points, but not less than zero. In 2003 and subsequent years, the update is CPI-U.	Section 626. In FY2004, starting April 1, 2004, the ASC update will be the CPI-U (estimated as of March 31, 2003) minus 3.0 percentage points. In FY2005, the last quarter of calendar year 2005, and each of the calendar years 2006 through 2009 the update will be 0%. A revised payment system for surgical services furnished in an ASC will be implemented on or after January 1, 2006 and not later than January 1, 2008. It will be budget neutral in its implementation year. There will be no administrative or judicial review of the ASC classification system, relative weights, payment amounts and any geographic adjustments. GAO will study the relative costs of ASC procedures.	No provision.	Section 625. The reduction in the update would be reestablished for FY 2004 - FY 2008. ASCs would get an increase calculated as the CPI-U minus 2.0 percentage points (but not less than zero) in each of the fiscal years from 2004 through 2008.
Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) Services			
Increase payments for rural health clinics. BBA 1997 extended the per visit payment limits that had existed for independent rural health clinics to provider-based rural health clinics (RHC) except for those clinics based in small rural hospitals with fewer than 50 beds. For services rendered from January 1, 2003 through February 28, 2003, the RHC upper payment limit is \$66.46, which reflects a 2.6% increase in 2002 payment limit as established by the 2002 Medicare Economic Index (MEI). For	No provision.	Section 428. The RHC upper payment would be increased to \$80.00 for calendar year 2005. The MEI applicable to primary care services would be used to increase the payment limit in subsequent years.	No provision.

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services rendered from March 1, 2003 through December 31, 2003, the Medicare RHC upper payment limit is \$66.72, which reflects a 3.0% increase in the 2002 payment limit as established by the 2003 MEI. The 2002 MEI was used as an update for 3 months because of the delayed implementation.			

Covered Part B Outpatient Drugs (Not Provided by a HOPD)

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Pay for existing outpatient drugs provided incident to a physician's services. Although Medicare does not currently have an outpatient prescription drug benefit, it covers approximately 450 outpatient drugs and biologicals authorized by statute, including those: (1) that are covered if they are usually not self-administered and are provided incident to a physician's services; (2) those that are necessary for the effective use of covered durable medical equipment; (3) certain self-administered oral cancer and anti-nausea drugs (those with injectable equivalents); (4) erythropoietin (used to treat anemia); (5) immunosuppressive drugs after covered Medicare organ transplants; (6) hemophilia clotting factors; and (7) vaccines for influenza, pneumonia, and hepatitis B. Payments are based on 95% of the average wholesale price (AWP) published in industry reference publications. AWP does not account for discounts routinely offered to providers and physicians. Current Medicare payment rates are 95% of AWP for brand name drugs produced by a single manufacturer (or single source drugs). Medicare will pay 95% of the lower of (a)	Section 303(b) In general, payments for most covered Part B drugs, including intravenous immune globulin, furnished in 2004 will equal 85% of the average wholesale price (determined as of April 1, 2003). Certain categories of drugs and biologicals (drug products) will continue to be paid at 95% of the AWP including blood products and clotting factors furnished during 2004; a drug product furnished during 2004 that was not available for Part B payment as of April 1, 2003; pneumococcal, influenza, and hepatitis B vaccines; and a drug or biological (other than erythropoietin) furnished in connection with renal dialysis services that are separately billed by renal dialysis facilities. Drug products paid at 85% of AWP in 2004 may be paid a different amount if the widely available market price is different than the payment amount for the year. Also payments may be adjusted because of data submitted by the manufacturer or by another entity by October 15, 2003. In no case will payment be less than 80% of AWP. Section 303(c) Beginning in 2005, drug products, except for pneumococcal,	Section 432(a). In 2004, existing drugs (available by April 1, 2003) would be paid the lower of the widely available market price or 85% of the listed AWP as of Apr. 1, 2003 as subsequently increased by the CPI for medical care as of June. The Secretary would be required to determine whether the widely available market price is different from the AWP amounts using any HHS-IG or GAO report issued in 2000 and later as well as other data from purchaser, supplier and manufacturers. If different, the widely available market price would be treated as the AWP amount in 2004 and subsequently. However, if that difference is more than 15%, payments would be reduced in 15% increments of Medicare's prior year payment. This transition would not apply to those with generic versions in the market beginning 2004. After Jan. 1, 2004, payments for covered vaccines would be equal to the AWP.	Section 303(b). Physicians who opt out of the competitive acquisition program (which is described subsequently) would be paid under a new, separate 1847B payment method. Subject to the beneficiary cost-sharing, non-generic drugs would be paid 112% of the applicable price in 2005 and 2006 and 100% of the price subsequently. The multiple source drug applicable price would be the reported volume-weighted average of the average sales price; the applicable price for a single source drug would be the lesser of the manufacturer's average sales price (ASP) for the NDC code or the reported wholesale acquisition cost (WAC). Payments would not account for special packaging, labeling or identifiers on the dosage form or product or package. By April 1, 2004, the ASP would be calculated by NDC each calendar quarter by dividing a manufacturer's total sales by the units sold in that quarter with certain adjustments to account for volume discounts and other rebates. Certain sales would be exempt from the calculation. The WAC would be the manufacturer's list price to wholesalers or direct purchasers for the most recent available month, not including discounts or other price reductions, as reported in wholesale price guides or other pricing publications. Payment rates would be updated on a quarterly basis. Certain contractors would determine the payment amounts. Certain standards would define multiple and single

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<p>the median AWP of all generic drugs or (b) the lowest brand-name product AWP for drugs with two or more competing brand names (or multiple source drugs) or those drugs with available generic equivalents. Although Medicare uses the Healthcare Common Procedure Coding System (HCPCS) codes to pay for physician administered drugs, the AWPs are established for national drug codes (NDC) which provides data on chemical molecule, drug manufacturer, dosage, dosage form and package size.</p>	<p>influenza, and hepatitis B vaccines, those associated with certain renal dialysis services, blood products and clotting factors and radiopharmaceuticals, will be paid using either the average sales price methodology or through the competitive acquisition program. Medicare's payment under the average sales price (ASP) methodology will equal 106% of the applicable price for a multiple source drug or single source drug subject to beneficiary deductible and coinsurance amounts. The applicable price for multiple source drugs is the volume-weighted average of the average sale price calculated by NDC code for each calendar quarter. The applicable price for single source drugs is the lesser of the average sales price or the wholesale acquisition cost. Certain sales such as those to the Medicaid drug rebate program are exempt from the calculation, but the ASP will take into account certain discounts (not including Medicaid rebates). After 2004, the Secretary may include other price concessions recommended by the HHS-IG who will conduct market surveys. If the ASP exceeds the market price or average manufacturer price by a threshold percentage, the ASP may be disregarded. In 2005 the threshold is 5%; in 2006 and subsequent years, the percentage threshold will be specified by the Secretary. The payment amount will then be equal to the lesser of the widely available market price or 103% of the average manufacturer price. For drugs furnished in a year after 2004, the widely available market price is the price that a prudent physician or supplier would pay for a drug product, taking into account</p>		<p>source drugs and establish pharmaceutical equivalence. There would be no administrative or judicial review of the ASP.</p>

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	certain routinely available discounts. The wholesale acquisition cost or other reasonable measure may be used instead of the manufacturer's average sale price in the case of certain public emergencies. There will be no administrative or judicial review of determinations of payment amounts; the identification of units and package size; or the method used to allocate price concessions to a specific quarter among other items.		
Pay for new outpatient drugs provided incident to a physician's services. See above.	Section 303(c). Drug products during an initial period (not to exceed a full calendar quarter) when data on the prices for sales is not sufficiently available to compute ASP will be paid based on the wholesale acquisition cost or on the payment methods in effect as of November 1, 2003.	Section 432(a) continued. New drugs (available after April 1, 2003) would be paid based on the manufacturer's estimated price data. During the first and second years, the manufacturer would provide data on the actual market prices paid by physicians or suppliers which would be equal to the lesser of the AWP or the original estimate. Subsequently, payments would be equal to the lesser of the AWP or the widely available market price established for existing drugs. If no market price exists, the prior year's payment is increased by June's CPI for medical care. Other payment changes for the administration of drugs would be contingent on the implementation of these provisions.	Section 303(b) continued. New drugs. The Secretary would be able to disregard the average sales price during the first quarter of a new drug's sales if the price data is not sufficient to determine an average amount payable.
Establish competitive pricing program as an establish alternative pricing method for physicians who elect not to participate in competitive bidding program. See above	Section 303(d). Under the new Section 1847B, the Secretary is required to establish a competitive acquisition program to acquire and pay for competitively biddable drug products. The Secretary is required to compute an area average of the bid prices submitted, in contract offers accepted for the category and the area, for each year or other contract period. Medicare's program payment for these drugs will equal 80% of the average bid price after the Medicare	See above.	Section 303(b). Under new section 1847A, the Secretary would establish a competitive acquisition program to acquire and pay for covered outpatient drugs. Under this program, at least two contractors would be established in each competitive acquisition area (which would be defined as an appropriate geographic region) throughout the United States. Each year, a physician would be able to select a contractor who would deliver covered drugs and biologicals to the physician; as discussed above, a physician would be able to elect payment under the ASP payment methodology established by 1847B.

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	beneficiary meets the applicable deductible. Generally, coinsurance and deductible amounts will be collected by the contractor that supplies the drug product. There shall be no administrative or judicial review with respect to the establishment of payment amounts, contract awards, establishment of competitive acquisition areas, the phased-in implementation, the selection of categories of competitively biddable drugs and biologicals for competitive acquisition, or the bidding structure or number of contractors who are selected. No later than July 1, 2008, the Secretary is required to report to Congress on savings, reductions in cost-sharing, access to competitively biddable drugs and biologicals, the range of choices of contractors available to providers as well as beneficiary and provider satisfaction under the competitive acquisition program.		Blood clotting factors, drugs and biologicals furnished as treatment for end-stage renal disease (ESRD), radiopharmaceuticals, and vaccines would not be considered covered drugs under the competitive acquisition program.
Establish contracting requirements for competitive acquisition program. No provision in current law.	Section 303(d) Certain contractor selection and contracting requirements for the competitive acquisition program are established. Specifically, the Secretary is required to establish an annual selection process for a contractor in each area for each category of drugs and biologicals. The Secretary may not award the 3-year contract to any entity that does not have the capacity to supply the drug products or does not meet established quality, service, financial performance and solvency standards. The number of qualified entities selected in each category and area may be limited but will not be less than 2. All drugs and biological products distributed by a contractor must be acquired directly from the manufacturer or from a distributor that	No provision.	Section 303(b). The 1847A program would have two drug categories: the oncology drugs which would be implemented by 2005 and the non-oncology drugs which would be implemented by 2006. Certain contractor selection and contracting requirements for the program would be established. Specifically, the Secretary would establish an annual selection process for a contractor in each area for each of the two categories of drugs. The Secretary may not award the 2-year contract to any entity that does not meet capacity, quality, service, financial performance, solvency standards, conduct standards or disclosure requirements. The number of qualified entities selected in each category and area may be limited but will not be less than 2. As part of the awarded contract, the selected contractor would be required to disclose the reasonable, net acquisition costs regularly (but not more often than once a quarter) as specified by the Secretary. Contract offers could be

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
	has acquired the products directly from the manufacturer. The amount of the bid price will be required to be the same for all portions of the area. The appropriate contractor, as selected by the physician, will supply drug products directly to the physician, except in situations when a beneficiary is presently able to receive a drug at home or other appropriate non-physician office settings. Rules will be established relating to resupply of inventories, consistent with safe drug practices and with adequate safeguards against fraud and abuse. No applicable State requirements relating to the licensing of pharmacies are waived.		rejected if the aggregate average bid price exceeds the ASP under the 1847B process. The bid price would be required to be the same for all portions of the area. The appropriate contractor, as selected by the physician, would supply covered drugs directly to the physician, except under the circumstances when a beneficiary is presently able to receive a drug at home or at other specified non-physician office settings. Adequate safeguards against fraud and abuse and consistent with safe drug practices, in order for a physician to maintain a supply of drugs that may be needed in emergency situations, would be established.
Pay separately for the administration of blood clotting factors. Medicare will pay for blood clotting factors for hemophilia patients who are competent to use such factors to control bleeding without medical supervision as well as the items related to the administration of such factors.	Section 303(e)(1). The Secretary is required to review a GAO report and provide a separate payment for the administration of these factors. The total amount of payments for blood clotting factors furnished in CY2005 can not exceed the amount that would have otherwise been expended. In CY2006 and subsequently, this separate payment amount would be updated by the change in the CPI for medical care for the previous year ending in June.	Section 432(b)(4). The Secretary would be required to review a GAO report and provide a separate payment for the administration of these factors. These payments in CY2004 would not exceed the amount that would have otherwise been expended. In CY2005 and subsequently, the separate payment amount would be updated by June's CPI for medical care.	Section 303(f). MedPAC would be required to submit to Congress specific recommendations with respect to payment for blood clotting factors and its administration in its 2004 annual report.
Pay the physician a pharmacy dispensing fee. Medicare pays for certain outpatient prescription drugs and biologicals. For instance, Medicare pays a dispensing fee in conjunction with inhalation therapy drugs used in nebulizers. Medicare does not pay a dispensing fee to pharmacists or providers who supply oral drugs.	Section 303(e)(2). The Secretary is required to pay a dispensing fee (less the applicable deductible and coinsurance amounts) to licensed approved pharmacies for covered immunosuppressive drugs, oral anti-cancer drugs, and oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen.	Section 432(b)(8). Medicare would pay a dispensing fee (less applicable cost-sharing amounts) to licensed approved pharmacies for covered immunosuppressive drugs, oral anti-cancer drugs, and oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. Medicare would be able to pay a dispensing fee (less the applicable deductible and coinsurance amounts) to licensed approved pharmacies for other drugs and biologicals.	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Pay for discarded chemotherapy drugs. Medicare does not pay for chemotherapy drugs that are purchased by physicians, are not dispensed, and must be discarded.	No provision.	Section 432(b)(9). The Secretary would be able to pay a physician for chemotherapy drugs that are purchased with a reasonable intent to administer to a Medicare beneficiary but which cannot be administered despite the physician's reasonable efforts and must be discarded. Payment amounts for all covered chemotherapy drugs could be increased, subject to a 1% cap. The beneficiary's cost-sharing amounts would not be affected.	No provision.
Cover intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home. Intravenous immune globulin (IVIG) is a blood product prepared from the pooled plasma of donors. It has been used to treat a variety of autoimmune diseases, including mucocutaneous blistering diseases. It has fewer side effects than steroids or immunosuppressive agents. Effective October 1, 2002, IVIG is covered for the treatment of certain conditions for certain subpopulations. IVIG for the treatment of autoimmune mucocutaneous blistering diseases must be used only for short term therapy, but not as a maintenance therapy, for those for whom conventional therapy has failed.	Section 642. The provision covers intravenous immune globulin (IVIG) for the treatment in the home of primary immune deficiency diseases under Medicare. IVIG is defined as an approved pooled plasma derivative for the treatment, in the patient's home, of a patient with a diagnosed primary immune deficiency disease, if a physician determines administration of the derivative in the patient's home is medically appropriate. Items or services related to the administration of the derivative are not included. IVIG will be paid at 80% of the lesser of actual charge or the payment amount beginning January 1, 2004.	No provision.	Section 629. By January 1, 2004, IVIG for the treatment of primary immune deficiency diseases in the home would be included as a covered medical service, if a physician determines administration of the derivative in the patient's home is medically appropriate. This would not include items or services related to the administration of the derivative. Intravenous immune globulin would be paid at 80% of the lesser of actual charge or the payment amount.
Establish demonstration project to cover outpatient drugs. No provision in current law.	Section 641. A 2-year demonstration project will be established that will cover more than 50,000 patients and will pay for drug products that are prescribed as replacements for existing covered Part B drugs that are furnished incident to a physician's service which are not usually self-administered, including oral anticancer chemotherapeutic agents. The project is not permitted to cost more than \$500 million. The Secretary is	No provision.	Section 631. The Secretary would conduct a 2-year demonstration project in three states covering more than 10,000 patients under Part B that would pay for drugs and biologicals that are prescribed as replacements for existing covered drugs that are furnished incident to a physician's professional service and which are not usually self-administered including oral anti-cancer chemotherapeutic agents. The project would not extend beyond Dec. 31, 2005 and would not cost more than \$100 million.

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	required to submit an evaluation to Congress no later than July 1, 2006. The project will begin 90 days from enactment and end no later than December 31, 2005.		
Require GAO report on impact of drug provisions on beneficiary access to covered drugs. No provision in current law.	No provision.	Section 432(e). GAO would examine the impact of the drug provisions on the access of Medicare beneficiaries' to covered drugs and biologicals which would be due to Congress no later than January 1, 2006.	Section 303(e). Same provision except report would be due 2 years after the implementation of the competitive acquisition program (January 1, 2007).
Require HHS-IG reports on market prices for drugs. No provision in current law.	Section 303(c). The HHS-IG will submit a study to Congress on the adequacy of ASP payments for cancer treatments by October 1, 2005. The Secretary will submit a report to Congress by January 1, 2006 on the sales of drugs and biologicals to large volume purchasers to determine whether the price at which drugs and biologicals are sold to these purchasers represent the price made available to physicians and recommend whether these sales should be excluded from the ASP computation.	Section 432(e). The HHS IG would be required to conduct one or more studies that compare the market prices to Medicare payments for drugs that represent the largest portion of Medicare spending on such items.	No provision.
Require study on non-oncology codes. No provision in current law.	No provision.	No provision.	Section 303(h). The Secretary would be required to submit a study to Congress within 1 year of enactment that examines the appropriateness of establishing and implementing separate codes for non-oncology infusions that address the level of complexity and resource consumption. If deemed appropriate, the Secretary would be able to implement appropriate changes in the payment methodology.
Self-Injected Drugs and Biologicals			
Pay for selected self-injected drugs and biologicals. Coverage of certain outpatient drugs and biologicals is authorized by statute. Under Medicare Part B, these items are covered if they are	No provision.	Section 450E. In 2004 and 2005, Medicare would cover FDA approved self-injected biologicals that are prescribed as complete replacements for currently covered drugs in physicians'	No provision.

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usually not self-administered and are provided incident to a physician's services. Generally, Medicare will cover an outpatient drug as usually self-administered if it is delivered by intramuscular injection, but not if it is injected subcutaneously.		offices or as usually self-administered outpatient hospital services and other self-injected drugs that are used to treat multiple sclerosis.	

Covered Drugs and Services at a Dialysis Facility

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Establish the composite rate and payments for covered drugs and services in a dialysis facility. Dialysis facilities providing care to end stage renal disease (ESRD) beneficiaries receive a fixed prospectively determined payment amount (the composite rate) for each dialysis treatment, regardless of whether services are provided at the facility or in the patient's home. Medicare pays separately for erythropoietin (EPO) which is used to treat anemia for persons with chronic renal failure who are on dialysis. Congress has set Medicare's payment for EPO at \$10 per 1,000 units whether it is administered intravenously or subcutaneously in dialysis facilities or in patients' homes. Providers receive 95% of the AWP for separately billable injectable medications other than EPO administered during treatments at the facility.</p>	<p>Section 623. The bill increases the composite rate for renal dialysis by 1.6% for 2005. The bill requires the Secretary to establish a <i>basic</i> case-mix adjusted prospective payment system for dialysis services. The basic case-mix adjusted system is required to begin for services furnished beginning January 1, 2005. The system is required to adjust for a limited number of patient characteristics (the case-mix). The basic case-mix adjusted system is composed of two components: (1) those services which currently comprise the composite rate (including the 1.6% increase in 2005), and (2) the spread on separately billed drugs and biologicals (including erythropoietin and as determined by the HHS-IG reports).</p> <p>Drugs and biologicals (including erythropoietin) currently billed separately, will continue to be billed separately under the basic case-mix adjusted system. They cannot be bundled into the new system.</p>	<p>Section 432(b)(5). In 2004 the composite rate would be increased so that the sum of these payments plus the payments for non-EPO drugs and biologicals billed separately equal payments that would have been made without enactment of the drug pricing provisions in this legislation. During 2005, the ESRD rate would be increased by 0.05% and further increased by 1.6%. During 2006, the rate would be increased by 0.05% and then further increased by 1.6%. During 2007 and subsequently, the ESRD rate of the previous year would be increased by 0.05%. In any year after 2004, the Secretary would be required to provide for additional increases in the composite rate to account for any payment reductions for separately administered drugs (but not EPO) in the same manner as in 2004. These payment amounts, methods or adjustments would not be subject to administrative or judicial review.</p>	<p>Section 623(c). The ESRD composite payment rate would increase by 1.6% for 2004.</p>
<p>Restore composite rate exception for pediatric facilities. Prior to BIPA, an increase in the composite rate would trigger an opportunity for ESRD facilities to request a rate exception in order to receive higher payments. BIPA required the Secretary to develop an new ESRD payment system and prohibited the granting of new</p>	<p>Section 623. The prohibition on exceptions contained in BIPA section 422(a)(2) does not apply to pediatric ESRD facilities as of October 1, 2002. Pediatric ESRD facilities are defined as renal facilities with 50% of their patients under 18 years old. The provision is effective upon enactment.</p>	<p>No provision</p>	<p>Section 623(b). The prohibition on exceptions would not apply to pediatric ESRD facilities as of October 1, 2002. Pediatric facilities would be defined as a renal facility</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>exceptions with respect to applications received after July 1, 2001.</p> <p>Change requirements for existing end-stage renal disease demonstration project. The Secretary announced a demonstration project establishing a disease-management program that will allow organizations experienced with treating ESRD patients to develop financing and delivery approaches to better meet the needs of beneficiaries with ESRD.</p>	<p>Section 623. By October 1, 2005, the Secretary is required to report to Congress on the elements and features for the design and implementation of a fully case-mix adjusted, bundled prospective payment system for services furnished by ESRD facilities. The Secretary is required to establish a 3-year demonstration project of the fully case-mix adjusted payment system for ESRD services, beginning January 1, 2006 and consult with a required advisory board in carrying out the demonstration.</p>	<p>No provision.</p>	<p>with 50% of its patients under 18 years old.</p> <p>Section 623(a). The provision would require the Secretary to establish an advisory board for the ESRD disease management demonstration.</p>

Durable Medical Equipment (DME) and Related Outpatient Drugs

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Pay for home infusion drugs. Medicare will cover outpatient prescription drugs and biologicals if they are necessary for the effective use of covered durable medical equipment (DME), including those drugs which must be put directly into the equipment such as tumor chemotherapy agents used with infusion pump (home infusion drugs).</p>	<p>Section 303(b). Infusion drugs furnished through covered durable medical equipment starting January 1, 2004 will be paid 95% of the AWP in effect on October 1, 2003; starting January 1, 2007, infusion drugs furnished in any area covered by the DME competitive acquisition program will be paid at the competitive price.</p>	<p>Section 432(b)(6). The Secretary would be able to make separate payments for infusion drugs and biologicals furnished through covered DME beginning January 1, 2004 if such payments are determined to be appropriate. Total amount of payments for the infusion drugs in the year could not exceed the total amount of spending that would have occurred without enactment of this legislation.</p>	<p>Section 302. Infusion drugs would be covered under the competitive bidding project.</p>
<p>Payment for inhalation therapy. As mentioned above, Medicare will cover outpatient prescription drugs and biologicals if they are necessary for the effective use of covered durable medical equipment (DME), including those drugs which must be put directly into the equipment such as respiratory drugs given through a nebulizer (inhalation drugs).</p>	<p>Section 305. Inhalation drugs or biologicals furnished through covered durable medical equipment will be paid at 85% of the AWP (determined as of April 1, 2003) in 2004 and by the amount provided under the average sales price methodology in 2005 and subsequently. GAO is be required to conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the Medicare program and submit the results of the study in a report to Congress no later than</p>	<p>Section 432(b)(7). The Secretary would be able to increase payments for covered DME associated with inhalation drugs and biologicals and make separate payments, if appropriate, for those furnished through covered DME beginning January 1, 2004. The associated spending in any year would not exceed the 10% of the difference of the savings for these drugs attributed to this legislation.</p>	<p>Section 302. The competitive acquisition program would include drugs and supplies used in conjunction with DME, including inhalation therapy.</p> <p>Section 302. The competitive acquisition program would include drugs and supplies used in conjunction with DME, including inhalation therapy. Section 602(c). GAO would be required to conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the Medicare program</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
	1 year from the enactment date of this legislation.		and submit the results of the study in a report to Congress no later than May 1, 2004.
<p>Establish payments for durable medical equipment (DME). Medicare pays for DME and PO, using different fee schedules for each class of covered item that are subject to different floors and ceilings, calculated either on a state, regional, or national basis. BBA 1997 amended Medicare law to freeze DME fee schedule allowances for 5 years, beginning in 1998. POs were subject to a 1% increase for 5 years, beginning in 1998. BBA 97 also required the Secretary to undertake a competitive bidding demonstration for DME which occurred at two sites: Polk County, Florida and San Antonio, Texas. Class III medical devices are devices that sustain or support life, are implanted, or present potential unreasonable risk (e.g., implantable infusion pumps and heart valve replacements) and are subject to premarket approval, the most stringent regulatory control.</p>	<p>Section 302(b). The bill establishes a competitive acquisition program for DME (including items used in infusion and drugs), medical supplies, home dialysis supplies, therapeutic shoes, enteral nutrients, equipment, and supplies, electromyogram devices, salivation devices, blood products, and transfusion medicine, and off-the-shelf orthotics (requiring minimal self-adjustment for appropriate use). This program will replace the Medicare fee schedule payments. Exclusions from the competitive acquisition are: inhalation drugs; parenteral nutrients, equipment, and supplies; and class III devices (those that sustain or support life, are implanted, or present potential unreasonable risk and are subject to premarket approval by the Food and Drug Administration). In starting the programs, the Secretary is required to establish competitive acquisition areas, but would be able to exempt rural areas and areas with low population density within urban areas that are not competitive, unless a significant national market exists through mail order for a particular item or service. The programs will be phased-in so that competition under the programs occurs in 10 of the largest metropolitan statistical areas in 2007. The Secretary is permitted to phase-in first items and services with the highest cost and highest volume, or those items and services that the Secretary determines have the largest savings potential. The Secretary is required to report to Congress by July 1, 2009, on savings, reductions in cost-sharing, access to items and services, and beneficiary satisfaction under the competitive acquisition program.</p>	<p>Section 430. Medicare would not increase the DME fee schedule amounts in any of the years from 2004 through 2010 and would update the amounts by the CPI-U in each subsequent year. Payments for orthotic devices that have not been custom-fabricated would be similarly affected. Class III medical devices would be exempt from the freeze in DME payments. Prosthetics, prosthetic devices, and custom-fabricated orthotics would be updated by the percentage change in the CPI-U.</p>	<p>Section 302. Competitive acquisition programs for durable medical equipment, medical supplies, items used in infusion, drugs and supplies used in conjunction with durable medical equipment, medical supplies, home dialysis supplies, blood products, parental nutrition, and off-the-shelf orthotics (requiring minimal self-adjustment for appropriate use) would replace the fee schedule payments. Enteral nutrients and class III devices would not be covered by the program. Rural areas and areas with low population density within urban areas would be able to be exempt, unless a significant national market exists through mail order for a particular item or service. The programs would be phased-in over 3 years with at least one-third of the areas implemented in 2005 and two-thirds of the areas implemented in 2006. High-cost items and services would be required to be phased-in first. Certain requirements for the competitive acquisition program would be established. A Program Advisory and Oversight Committee would be established. The Secretary would be able to use this payment information to adjust the payment amounts for DME not in a competitive acquisition area. In this instance, the inherent reasonableness rule would not be applied.</p>
<p>Establish accreditation standards and process for DME suppliers. Medicare law requires DME suppliers to meet certain</p>	<p>Section 302(a). DME companies and suppliers will be subject to an accreditation and quality assurance process. The Secretary is required to</p>	<p>Section 430(c). DME companies and suppliers would be subject to an accreditation and quality assurance process.</p>	<p>Section 302. The competitive bidding project would establish certain quality standards for DME products no later than July 1, 2004.</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
requirements in order to participate in the program. Medicare law does not authorize the Secretary to deem accreditation by an independent entity as a substitute for onsite inspection by CMS.	designate independent accreditation organizations no later than 1 year from enactment. The Secretary is required to establish standards for clinical conditions for payment for covered durable medical equipment that include the specification of types or classes of covered items that require, as a condition of payment, a face-to-face examination and a prescription for the item. Beginning with the date of enactment, payment may not be made for motorized or power wheelchairs unless a physician, physician assistant, nurse practitioner, or a clinical nurse specialist has conducted a face-to-face examination of the individual and written a prescription for the item. Medicare payment is not permitted unless the item meets the standards established for clinical condition of coverage.	The Secretary would be required to designate independent accreditation organizations no later than 6 months from enactment after consultation with an expert outside advisory panel. The application of quality standards would be phased-in over a 3-year period.	
Cover total body orthotic management services for certain nursing home residents . Orthotics are rigid devices, or braces, which are applied to the outside of the body to support or restrict movement in a body part. Orthotics are covered Part B benefits when furnished in an institutional setting, such as in a hospital or skilled nursing facility, while durable medical equipment (DME) is not covered in those settings, because Medicare law requires that covered DME be appropriate for use in home.	No provision.	Section 450B. Medicare would pay for qualified total body orthotic management devices provided by qualified practitioners and suppliers no later than 60 days from enactment. These medically prescribed devices would consist of custom fitted individual braces that are attached to a frame that is integral to the device for a full-time patient of a skilled nursing facility who requires such medical care.	No provision.
Pay for certain custom shoes for diabetic patients. Subject to specified limits and under certain circumstances, Medicare will pay for extra-depth shoes with inserts or custom molded shoes with inserts for an individual with severe diabetic foot disease. Diabetic shoes are neither considered DME nor orthotics, but a separate category of coverage under Medicare Part B.	Section 627. Starting January 1, 2005, payment for diabetic shoes is limited to the amount that would be paid if they were considered to be a prosthetic or orthotic device. The Secretary may establish lower payment limits than these amount if shoes and inserts of an appropriate quality are readily available at lower amounts. The Secretary is required to establish a payment amount for an individual substituting modifications to the covered shoe that would	No provision.	Section 626. As of January 1, 2004, diabetic shoes would be paid as if they were considered to be a prosthetic or orthotic device. The Secretary or a carrier would be able to establish lower payment limits than these amounts if shoes and inserts of an appropriate quality are readily available at lower amounts. The Secretary would be required to establish a payment amount for an individual substituting modifications to the

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	assure that there is no net increase in Medicare expenditures.		covered shoe that would assure that there is no net increase in Medicare expenditures.

Ambulance Services

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Increase ambulance fee schedule. Traditionally, Medicare has paid suppliers of ambulance services on a reasonable charge basis and paid provider-based ambulances on a reasonable cost basis. BBA 1997 provided for a national fee schedule which was to be implemented in phases. The required fee schedule became effective April 1, 2002 with full implementation by January, 2006. In the transition period, a gradually decreasing portion of the payment is to be based on the prior payment methodology.</p>	<p>Section 414 (b). Medicare's payments for ground ambulance services will be increased by one quarter of the payment per mile rate otherwise established for trips longer than 50 miles occurring on or after July 1, 2004 and before January 1, 2009. The payment increase applies regardless of where the transportation originates.</p> <p>Section 414(c). The Secretary will provide a percentage increase in the base rate of the fee schedule for ground ambulance services furnished on or after July 1, 2004 and before January 1, 2010 that originate in a qualified rural area. The qualified rural areas are those with lowest populations densities that collectively represent a total of 25% of the population in those areas. To the extent feasible, the Secretary is required to treat certain rural census tracts in metropolitan statistical areas as rural areas. There will be no administrative or judicial review under Sections 1869 and 1878 of the SSA or otherwise with respect to the identification of a qualified rural area. In order to promptly implement this provision, the Secretary may use data furnished by GAO.</p> <p>Section 414(c). The payments for ground ambulance services originating in a rural area or a rural census tract will be increased by 2% (after application of the long trip and low density payment increases) for services furnished on or after July 1, 2004 through</p>	<p>Section 425. Payments for ground ambulance services originating in a rural area or a rural census tract would be increased by 5% for services furnished January 1, 2005 through December 31, 2007. The fee schedule for other areas would be increased by 2%. These increased payments would not affect subsequent periods. The ambulance conversion factor would not be adjusted downward because of the evaluation of the prior year's conversion factor.</p>	<p>Section 410. The base rate for ground ambulance services that originate in a qualified rural area would be increased after January 1, 2004 by the average costs per trip for the base rate in the lowest quartile as compared to the average cost for the base rate in the highest quartile of all rural counties. A qualified rural county is a rural area (a county not assigned to a metropolitan statistical area) with a population density of Medicare beneficiaries in the lowest quartile of all rural counties.</p>

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	December 31, 2007. The fee schedule for ambulances in other areas (after application of the long trip adjustment) will increase by 1%. These increased payments will not affect Medicare payments for covered ambulance services after 2006. A GAO report is required.		
Change ambulance fee schedule. In the transition period from 2002-2006, payment is based on a blend with a gradually increasing portion of the payment based on the fee schedule and a decreasing portion on the former payment method (of either reasonable costs for ambulance providers or reasonable charges for ambulance suppliers.) In 2003, the blend is 40% of the fee schedule and 60% of the cost or charge rates.	Section 414(a). Payments for ambulance services will be based on either the national fee schedule amount or a blended rate of the national fee schedule and a regional fee schedule, whichever results in the larger payment. The blended rate during the phase-in period will incorporate a decreasing portion of the payment based on regional fee schedules calculated for each of nine census regions. For 2004, starting for services on July 1, 2004, the blended rate is based on 20% of the national fee schedule and 80% of the regional fee schedule; for 2005, the blended rate is based on a 40% national and 60% regional split; in 2006, the blended rate is based on a 60% national and 40% regional split; in 2007, 2008 and 2009, the blended rate is based on a 80% national and 20% regional split; and in 2010 and subsequently, the ambulance fee schedule is based on the national fee schedule.	No provision.	Section 622. Payments would be incorporate a regional fee schedule, if that would result in a larger payment to the ambulance provider or supplier. The blended rate from 2004 through 2010 would incorporate a decreasing portion of the regional fee schedules calculated for each of nine census regions. Full phase-in to the existing fee schedule would occur by 2010. Medicare's payments for ground ambulance services would be increased by one quarter of the amount otherwise established for trips longer than 50 miles occurring beginning January 1, 2004 and before January 1 2009. A GAO report would be required.
Increase coverage for air ambulance services. Medicare pays for ambulance services under a fee schedule. Seven categories of ground ambulance services, ranging from basic life support to specialty care transport, and two categories of air ambulance services are established. Payment for ambulance services can only be made if other methods of transportation are contraindicated by the patient's medical conditions, but only to the extent provided in regulations.	Section 415. Regulations will provide that air ambulance services will be covered if: (1) such service is reasonable and necessary based on the patient's health condition at or immediately prior to the time of the transport service; and (2) the air ambulance service complies with established equipment and crew requirements. An air ambulance service is considered reasonable and necessary when requested: (1) by a physician or other qualified medical personnel who reasonably determines that the time need to transport by land or the instability of such	Section 426. For services furnished beginning January 1, 2005, the regulations governing ambulance services would be required to ensure that air ambulance services be covered if: (1) the air ambulance service is medically necessary based on the health condition of the patient being transported at or immediately prior to the time of the transport service; and (2) the air ambulance service complies with the equipment and crew requirements established by the Secretary. These services would be a fixed wing or rotary wing air ambulance services.	No provision.

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	transport threatens the patient's health or survival; or (2) such services are furnished pursuant to a protocol that is established by a state or regional emergency medical services (EMS) agency and approved by the Secretary. The EMS agency cannot have an ownership interest in the entity furnishing such service. Also, there cannot be a financial, employment or ownership relationship between the person (or immediate family member) requesting the service and the furnishing entity. This prohibition does not apply to certain instances when a hospital and an entity furnishing the rural air ambulance services are under common ownership. A rural air ambulance service is defined as a fixed wing or rotary wing air ambulance service where the patient pick up occurs in a rural area or rural census tract. The provision applies to services on or after January 1, 2005.		

Other Part B Services and Provisions

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Establish 2-year moratorium on therapy caps. BBA 97 established annual payment limits per beneficiary for all outpatient therapy services provided by non-hospital providers. The cap applied in 1999. BBRA and BIPA suspended application for 2000 through 2002. Enforcement was delayed until September 1, 2003.	Section 624. Application of the therapy caps is suspended for the remainder of 2003 (after enactment), in 2004 and 2005. The Secretary is required to submit the reports required by BBA 97 and BIPA by March 31, 2004 relating to the alternatives to a single annual dollar cap on outpatient therapy and the utilization patterns for outpatient therapy. The GAO is required to identify conditions or diseases that may justify waiving the application of the therapy caps and report to Congress by October 1, 2004.	No provision.	Section 624. Application of the therapy caps would be suspended in 2004. Provisions with respect to existing report requirements are included.
Cover routine costs associated with clinical trials. Currently, Medicare covers	Section 731. The Secretary is prohibited from excluding from Medicare coverage the routine costs of	Section 438. After January 1, 2005, the routine costs of care for Medicare	Section 733. The routine costs of care for Medicare beneficiaries participating in

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
the routine costs of qualifying clinical trials without explicit statutory instruction. However, Medicare does not pay for certain aspects of the clinical trial including: the investigational item or service, items and services not used in the direct clinical management of the patient, and items and services customarily provided by the research sponsor free of charge for any enrollee in the trial.	care incurred by a Medicare beneficiary participating in a category A clinical trial, beginning with routine costs incurred on and after January 1, 2005. This provision does not apply to, or affect, Medicare coverage or payment for a non-experimental/investigational (category B) device.	beneficiaries participating in clinical trials would be covered by statute. The Secretary would not be required to modify the existing regulations. Total Medicare expenditures associated with this provision would not exceed specified limits that start at \$32 million in 2005 and increase gradually to \$50 million in 2013.	clinical trials that are conducted in accordance with an investigational device exemption approved under Section 530(g) of the Federal Food, Drug, and Cosmetic Act would be covered. Any clinical trial established on the date of enactment or after would be covered. Services provided on or after enactment would be covered.
Cover certain vision rehabilitation services. Medicare does not cover routine eye care or related services and will not pay for eyeglasses; most contact lenses; eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses; and most procedures performed to determine the refractive state of the eyes. A CMS program memorandum issued May 29, 2002, clarified that Medicare beneficiaries who are blind or visually impaired are eligible for physician-prescribed rehabilitation services from approved health care professionals on the same basis as beneficiaries with other medical conditions that result in reduced physical functioning.	Section 645. The Secretary is required to study the feasibility and advisability of providing for payment for vision rehabilitation services furnished by vision rehabilitation professionals. The report is due to Congress by January 1, 2005.	Section 446. Medicare Part B would cover vision rehabilitation services furnished to a beneficiary who is diagnosed with certain vision impairments. Covered services would be established by a plan of care developed by a qualified physician or qualified occupational therapist whose plan of care is periodically reviewed by a qualified physician. Medicare would pay for the services under the physician fee schedule.	No provision.
Cover marriage counseling and family therapy. Medicare will cover services connected with the treatment of a mental, psychoneurotic, or personality disorder of an individual who is not an inpatient of a hospital at the time such expenses are incurred. The term “treatment” does not include brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by the physician. Family counseling services with members of the household are covered only where the	No provision.	Section 448. Starting January 1, 2004, Medicare would cover marriage and family therapist services and mental health counselor services for the diagnosis and treatment of mental illness. Payment amounts would be 80% of the lesser of the actual charge or 75% of the amount paid to a psychologist. These services would be subject to assignment. Rural health clinics, federally qualified health centers, and hospice programs would be authorized to provide such services. Marriage and family therapists would be authorized to develop post hospital discharge plans for patients.	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
primary purpose of such counseling is the treatment of the patient's condition.			
Cover all Part B services provided by Indian hospitals and clinics. Medicare covers specific Part B services provided by a hospital, skilled nursing facility, or ambulatory care clinic (whether provider-based or freestanding) that is operated by the Indian Health Service or by an Indian tribe or tribal organization.	Section 630. The bill provides a 5-year expansion of the items and services covered under Medicare Part B when furnished in Indian hospitals and ambulatory care clinics. The bill applies to items and services furnished on or after January 1, 2005.	Section 450C. All Medicare Part B items and services provided by hospitals, skilled nursing facilities, or ambulatory care clinics operated by the Indian Health Service or by an Indian tribe or organization beginning October 1, 2004 would be paid.	No provision.
Cover cardiovascular screening tests. Medicare covers a number of preventive services. However, it does not cover cardiovascular screening tests.	Section 612. Medicare will cover cardiovascular screening blood tests beginning January 1, 2005. The Secretary is required to establish standards regarding the frequency of these screening tests, but not more often than once every 2 years.	Section 450D. Beginning January 1, 2005, Medicare would cover cardiovascular diagnostic testing including tests for cholesterol levels, lipid levels of the blood, and other tests identified after consultation with appropriate organizations to establish the frequency and type of these screening tests which could occur no more often than once every 2 years.	Section 612. Medicare coverage of cholesterol and blood lipid screening would be authorized. The Secretary would be required to establish standards regarding the frequency and type of these screening tests, but not more often than once every 2 years.
Cover initial preventative physical examination. Medicare covers a number of preventive services. However, it does not cover routine physical examinations.	Section 611. Medicare will cover an initial preventive physical examination beginning January 1, 2005 for newly enrolling beneficiaries within 6 months of enrollment. Beneficiary cost sharing applies to initial preventive physical examinations.	No provision.	Section 611. Medicare coverage of an initial preventive physical examination would be authorized and paid for using the physician fee schedule. No beneficiary cost-sharing would be imposed.
Cover diabetes laboratory diagnostic tests. On July 1, 1998, Medicare began covering diabetes self-management training services. These educational and training services are provided on an outpatient basis by physicians or other certified providers who have experience in diabetes self-management training services.	Section 613. Medicare will cover diabetes screening tests furnished to individuals at risk for developing diabetes, beginning January 1, 2005.	No provision.	Section 630. Starting 90 days from enactment, diabetes screening tests and services would be included as a covered medical service for individuals at high-risk for developing diabetes.
Cover kidney disease education services. No provision in current law.	No provision.	Section 456. Starting January 1, 2004, kidney disease education services would be covered and paid using Medicare's physician fee schedule on an assignment-related basis (and thus prohibiting balance billing) outside the ESRD composite rate.	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Increase providers eligible for payments for telehealth services. Medicare pays for telehealth services that are provided in specified “originating sites.” These originating sites are: physician or practitioner office, a critical access hospital, a rural health clinic, a Federally-qualified health center, or a hospital.</p> <p>Prohibit private insurers from requiring prior Medicare processing of dental claims. The Medicare benefit does not include most dental services. Some insurers may require a claim denial from Medicare before accepting the dental claim for payment review, even if the service is not covered by Medicare.</p>	<p>Section 418. The Administrator of the Health Resources and Services Administration is required to evaluate demonstration projects under which a skilled nursing facility is treated as an originating site for telehealth services. The report to Congress is due by January 1, 2005.</p> <p>Section 950. Group health plans providing supplemental or secondary coverage to Medicare beneficiaries cannot require dentists to obtain a claim denial from Medicare for dental services that are not covered by Medicare before paying the claim, beginning 60 days after enactment.</p>	<p>A report from the Secretary would be due to Congress by April 1, 2004.</p> <p>Section 450H. Other types of providers would be added to the list of originating sites that can bill Medicare for telehealth services. In addition, the Secretary would be required to encourage and facilitate the adoption of state provisions allowing for multi-state practitioner licensure across state boundaries.</p> <p>Section 555. A group health plan providing supplemental or secondary coverage to Medicare beneficiaries would not be able to require dentists to obtain a claim denial from Medicare for non-covered dental services before paying the claim.</p>	<p>No provision.</p> <p>Section 950. Same provision.</p>

Provisions Relating to Parts A and B

Home Health Services

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Increase for home health services furnished in a rural area. BIPA increased PPS payments by 10% for home health services furnished in the home of beneficiaries living in rural areas during the 2-year period beginning April 1, 2001, through March 31, 2003. The temporary additional payment was not included in the base for determination of payment updates.</p> <p>Reduce update for home health services. Home health service payments are increased on</p>	<p>Section 421. Home health agencies will receive a 1 year, 5% additional payment for home health care services furnished in a rural area without regard to certain budget-neutrality requirements. The temporary additional payment begins for episodes and visits ending on or after April 1, 2004 and before April 1, 2005 and cannot to be used in calculating future home health payment amounts.</p> <p>Section 701. Home health agency (HHA) payments are increased by the full market</p>	<p>Section 451. A 5% increase in payments for home health care services furnished in a rural area would be provided during FY 2005 and FY2006 without regard to certain budget neutrality requirements. The temporary additional payment would not be considered when determining future home health payment amounts.</p> <p>No provision.</p>	<p>Section 411. A 5% additional payment for home health care services furnished in a rural area would be provided during 2004 and 2005 without regard to certain budget neutrality requirements.</p> <p>Section 701. HHA payments would be increased by the home health market basket</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
a federal fiscal year basis that begins in October. The FY2004 statutory update will be the full increase in the market basket index.	basket percentage for the last quarter of 2003 (October, November, and December) and for the first quarter of 2004 (January, February, and March). The update for the remainder of 2004 and for 2005 and 2006 is the home health market basket percentage increase minus 0.8 percentage points. HHA payment updates are moved from the federal fiscal year to a calendar year basis beginning with 2004.		minus 0.4 percentage points for 2004 through 2006. The update for subsequent years would be the full market basket increase. The provision would also change the time frame for the update from the federal fiscal year to a calendar year basis. The home health PPS rates would not increase for the October 1 through December 31, 2003 period.
Establish demonstration project to clarify definition of homebound. A Medicare beneficiary must be confined to the home (or homebound) in addition to other criteria in order to qualify for the home health benefit.	Section 702. A 2-year demonstration project where beneficiaries enrolled in Medicare Part B with a permanent and severe disabling condition and with specified care needs would be deemed to be homebound in order to receive home health services under Medicare. The number of participants is limited to 15,000.	Section 450. A 2-year demonstration project where beneficiaries with chronic conditions would be deemed to be homebound in order to receive home health services under Medicare would be established.	Section 704. Substantially similar provision, however, beneficiaries would permanently need skilled nursing services (other than medication management); these skilled nursing services would need to be provided each day or an attendant would be needed during the day to monitor and treat the beneficiary's medical condition.
Establish adult day care demonstration project. No provision in current law.	Section 703. A demonstration project is required where a HHA, directly or under arrangement with a medical adult day care facility, will provide medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home.	Section 454. A demonstration would be established where a HHA, directly or under arrangement with a medical adult day care facility, would provide medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home.	Section 732. Same provision.
Suspend the requirement that Outcome and Assessment Information Set (OASIS) data be submitted for non-Medicare, non-Medicaid patients. Medicare is required to monitor the quality of home health care and services for all patients as part of the survey process with a standardized, reproducible assessment instrument. OASIS is the data collection instrument that is used.	Section 704. The requirement that HHAs must collect OASIS data on private pay (non-Medicare, non-Medicaid) patients is suspended until the Secretary reports to Congress on the benefits of these data.	Section 630. The requirement that HHAs must collect OASIS data on private pay (non-Medicare, non-Medicaid) patients would be suspended until the Secretary reported to Congress on the benefits of these data.	Section 954. Same provision.
Require MedPAC study on home health agency (HHA) margins. No provision in current law.	Section 705. MedPAC is required to study payment margins of HHAs paid under PPS, to examine whether systematic differences in payment margins are related to differences in case mix, as measured by home health resource groups (HHRGs), among agencies.	No provision.	Section 703. MedPAC would study payment margins of HHAs paid under PPS to examine whether systematic differences in payment margins were related to differences in case mix, as measured by HHRGs.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Coverage of religious nonmedical health care institution services furnished in the home. Under specified conditions, Medicare will make payment for services furnished to a beneficiary in a religious nonmedical health care institution.	Section 706. The definition of a home health agency is expanded to include a religious nonmedical health care institution, but only with respect to items and services ordinarily furnished by this institution to individuals in their homes and that are comparable to items and services furnished to individuals by HHAs. Payments are prohibited from exceeding \$700,000 in a year and are prohibited after December 31, 2006.	No provision.	No provision.
Increase for home health services furnished in a rural area. BIPA increased PPS payments by 10% for home health services furnished in the home of beneficiaries living in rural areas during the 2-year period beginning April 1, 2001, through March 31, 2003. Home health PPS makes additional outlier payments for extraordinarily costly cases; outlier payments may not exceed 5% of the total estimated payments for the fiscal year.	No provision.	Section 459. A 10% additional payment for home health care services furnished in a rural area during FY2005 and FY2006 would be provided without regard to certain budget neutrality requirements. The total amount of outlier payments would be reduced to no more than 3% of total payments in FY 2004 and 4% for FYs 2005 and 2006. [Duplicate provision is at Section 463].	No provision.
Limit reduction in area wage adjustment factors under home health PPS. In calculating PPS payment, the portion of the base payment amount that is attributable to wages and wage-related costs is required to be adjusted for those costs. The Secretary is required to calculate an area wage adjustment factor that is actually used to adjust the base payment amount. The factors change annually as new wage data are reported and areas change in relative costliness.	No provision.	Section 452. The provision would limit any reduction in the home health area wage adjustment factor for fiscal years 2005 and 2006. Any reduction could be no more than 3% less than the area wage adjustment factor applicable to home health services for the area in the previous year.	No provision.
Require GAO report on flexibility in applying home health conditions of participation (COP) to patients who are not Medicare beneficiaries. No provision in current law.	No provision.	No provision.	Section 953(d). GAO would report to Congress on the implications if Medicare's COPs for home health agencies were applied flexibly with respect to groups or types of patients who are not Medicare beneficiaries, include an analysis of the potential impact of this flexibility on clinical operations and the recipients of such services and analyze methods for monitoring the quality of care provided to these recipients. The report

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Establish beneficiary cost-sharing for home health services. The home health benefit does not have any cost-sharing requirement.</p>	No provision	No provision.	<p>would be due no later than 6 months after enactment.</p> <p>Section 702. A beneficiary copayment for each 60-day episode of care beginning January 1, 2004 would be established. The copayment amount would be 1.5% of the national average payment per episode in a calendar year, rounded to the nearest multiple of \$5. For 2004, the copayment would be \$40 unless otherwise calculated on a timely basis by the Secretary. Medicare payments would be reduced to reflect copayments. Qualified Medicare beneficiaries, beneficiaries dually eligible for Medicare and Medicaid, and beneficiaries receiving four or fewer home health visits in an episode of care would not face any cost-sharing requirements. Administrative and judicial review of the calculated copayment amounts would be prohibited.</p>

Chronic Care Improvement

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Cover chronic care improvement services under traditional fee-for-service. No provision in current law.</p>	<p>Section 721. The Secretary is required to establish and implement chronic care improvement programs for Medicare fee-for-service. The programs must be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets for Medicare for beneficiaries with certain chronic health conditions.</p>	<p>Section 443. The Secretary would be required to establish a 5-year budget neutral demonstration program that uses qualified care management organizations to provide health risk assessment and care management services to high-risk Medicare beneficiaries including those with multiple sclerosis or other disabling chronic conditions, nursing home residents or those at risk for placement, or high-risk dual eligible beneficiaries.</p>	<p>Section 721. Specified chronic care improvement services would be provided to certain beneficiaries with chronic conditions as a Medicare benefit, not as a demonstration project.</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Cover chronic care improvement services under Medicare Advantage. No provision in current law.	Section 722. Each Medicare Advantage organization is required to have an on-going quality improvement program for improving the quality of care provided to enrollees (except for private fee-for-service plans or MSA plans) effective for contract years beginning January 1, 2006. As part of the quality improvement program, each MA organization is required to have a chronic care improvement program. Each chronic care improvement program is required to have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.	Section 442. The Secretary would be required to establish a 3-year budget neutral demonstration program to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes before October 1, 2004. Six sites would be designated for the demonstration, three in urban areas and at least one in a rural area. One site would be required to be located in Arkansas. The Secretary would pay each principal care physician a monthly complex care management fee developed by the Secretary. The fee would be the full payment for all the functions performed.	Section 722. Comparable chronic care improvement services would be provided to beneficiaries in Medicare Advantage and Enhanced FFS as a Medicare benefit, not as a demonstration project.
Establish consumer- directed chronic outpatient services. No provision in current law. Medicare coverage requires that a beneficiary need medically necessary care. In general, Medicare pays the provider that delivers skilled health care services.	Section 648. The Secretary is required to establish no fewer than 3 demonstration projects that evaluate methods to improve the quality of care provided to Medicare beneficiaries with chronic conditions and that reduce expenditures that would otherwise be made on their behalf by Medicare. The methods are required to include permitting beneficiaries to direct their own health care needs and services. In designing the demonstrations, the Secretary is required to evaluate practices used by group health plans and practices under State Medicaid programs that permit patients to self-direct the provision of personal care services and to determine the appropriate scope of personal care services that apply under the demonstration projects.	No provision.	Section 736. The Secretary would establish no fewer than three demonstration projects to evaluate method to improve the care and reduce the cost of care provided to Medicare beneficiaries with chronic conditions including methods that would permit beneficiaries to direct their own health care needs and services. The Secretary would establish the demonstrations located in an urban area, a rural area, and an area that has a Medicare population with a diabetes rate that significantly exceeds the national average rate within 2 years of enactment. The Secretary would evaluate and submit reports to Congress on the cost and clinical effectiveness of the projects biannually beginning 2 years after their start.
Require Institute of Medicine (IOM) report related to chronic conditions. No provision in current law.	No provision.	No provision.	Section 723. The Secretary would contract with the IOM to study the barriers to effective integrated care

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
			improvement across settings and over time for beneficiaries with multiple or severe chronic conditions in transition from one setting to another.
Require MedPAC report related to chronic care improvement program. No provision in current law.	No provision.	No provision.	Section 724. MedPAC would evaluate the chronic care improvement program established in Section 721. The evaluation would include a description of the status of the implementation of the program, the quality of health care services provided to individuals participating in the program, and the cost savings attributed to the implementation of the program.

Medicare Secondary Payor (MSP)

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Modify MSP provisions. In certain instances, Medicare is prohibited from making payment for a health care claim if payment is expected to be made promptly by a primary plan. The definition of a primary plan includes a workmen's compensation law or plan, under automobile or liability insurance (including a self-insured plan) or under no-fault insurance on behalf of a beneficiary.	Section 301. The provision clarifies that the Secretary can make a conditional payment if a primary plan did not make a prompt payment or could not have reasonably been expected to make a prompt payment (as determined by regulations). Payment is contingent on reimbursement by the primary plan to the Medicare Trust Funds. An entity engaging in a business, trade, or profession is deemed as having a self-insured plan if it carried its own risk. Failure to obtain insurance is considered evidence of carrying risk.	Section 461. The provision would clarify that the Secretary could make a conditional payment if a primary plan did not make a prompt payment or could not have reasonably been expected to make a prompt payment (as determined by regulations). Payment would be contingent on reimbursement by the primary plan to the Medicare Trust Funds. An entity engaging in a business, trade, or profession would be deemed as having a self-insured plan if it carried its own risk. Failure to obtain insurance would be considered evidence of carrying risk.	Section 301. Same provision.
Extend MSP rules for individuals with end-stage renal disease (ESRD). The MSP provisions apply to group health plans for the working aged, large group health plans for the disabled, and, for 30 months, employer health plans for the ESRD population.	No provision.	Section 450F. This provision would extend the limited time period that employer health plans are primary payer for beneficiaries with end-stage renal disease to 36 months.	No provision.
Revise Medicare secondary payor requirements for diagnostic laboratory	Section 943. The Secretary is not permitted to require that a hospital obtain information on other	No provision.	Section 943. The Secretary would not be able to require that a

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
services. In certain instances when a beneficiary has other insurance coverage, Medicare becomes the secondary insurance. An entity furnishing a Part B service is required to obtain information from the beneficiary on whether other insurance coverage is available.	insurance coverage for reference laboratory services, if such requirements are not imposed in the case of services furnished by independent laboratories.		hospital obtain information on other insurance coverage for reference laboratory services, if the Secretary does not impose such requirements in the case of services furnished by independent laboratories.

Other Medicare A and B Provisions

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Establish self-referral exemption for certain arrangements in underserved areas. People who knowingly and willfully offer or pay a kickback, a bribe, or rebate to directly or indirectly induce referrals or the provision of services under a federal program may be subject to financial penalties and imprisonment. Certain exceptions or safe harbors that are not considered violations of the anti-kickback statute have been established.	Section 431. Remuneration between a public or non-profit private health center and an entity providing goods or services to the health center is not a violation of the anti-kickback statute if such an agreement would contribute to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved population. The Secretary is required to establish standards, on an expedited basis, related to this safe harbor with final regulations due within 1 year from enactment.	No provision.	Section 412. Remuneration between a public or non-profit private health center and an entity providing goods or services to the health center would not be a violation of the anti-kickback statute if such an agreement would contribute to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved population. The Secretary would be required to establish standards, on an expedited basis, related to this safe harbor with final regulations due within 1 year from enactment. CHECK.
Change self-referral provision as applied to specialty hospitals. Physicians are generally prohibited from referring Medicare patients to facilities in which they (or their immediate family member) have financial interests. Physicians, however, are not prohibited from referring patients to hospitals where they have ownership or investment interest in the whole hospital itself (and not merely in a subdivision of the hospital). Certain rural providers that provide substantially all of the designated health services to individuals residing in the rural	Section 507. The exception for physician investment and self-referral will not extend to specialty hospitals for 18 months from the enactment date. A specialty hospital is one that primarily or exclusively treats patients with a cardiac condition, an orthopedic condition, those receiving a surgical procedure, or other cases that the Secretary designates. A specialty hospital does not include any hospital that is determined by the Secretary to be in operation or under development as of November 18, 2003, with the same number of physician investors, categories of care, or limited increase in beds as of such date. Certain factors,	Section 453. The exception for physician investment and self-referral would not extend to specialty hospitals. In this instance, a specialty hospital would be one that is primarily or exclusively engaged in the cardiac, orthopedic, surgical care, or other specialized categories of patients or cases deemed appropriate. A specialty hospital would not include any hospital that is determined by the Secretary to be in operation before June 12, 2003, under development as of such date, with the same number of beds and physician	Section 505. MedPAC would be required to conduct a study of specialty hospitals compared with other similar general acute hospitals and report to Congress, including recommendations, no later than 1 year from enactment.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
area are also exempt from the self-referral restriction	such as whether architectural plans are done, will be considered when determining whether a hospital is under development. During this 18-month period, the exception will apply if substantially all of the designated services provided by the entity are furnished to individuals residing in the rural area and the entity is not a specialty hospital as defined previously. Reports from MedPAC and the Secretary on various aspects of specialty hospitals are due to Congress within 15 months of enactment.	investors as of such date. The Secretary would consider certain factors in determining whether a hospital is under development. The rural provider exception would be modified. These rural providers would not include specialty hospitals and the Secretary would determine, with respect to the entity, that such services would not be available in such area but for the ownership or investment interest.	
Change in national coverage determination process to respond to changes in technology. The Secretary has established procedures and timeframes for making national coverage decisions.	Section 731. The Secretary is required to make public the factors considered in making national coverage determinations. The following time frame for national coverage determinations is established—6 months when a technology assessment is not required and 9 months when a technology assessment is required and in which a clinical trial is not requested. After the 6- or 9-month period, the draft proposed decision is to be available on the HHS website or by other means to provide a 30-day public comment period. The final decision on the request must be made 60 days following the end of the public comment period. The Secretary is prohibited from excluding from Medicare coverage the routine costs of care incurred by a Medicare beneficiary participating in a category A clinical trial, beginning with routine costs incurred on and after January 1, 2005. This provision does not apply to, or affect, Medicare coverage or payment for a non-experimental/investigational (category B) device. Also, the Secretary is required to implement revised procedures for the issuance of temporary national HCPCS codes by July 1, 2004.	Section 458. The provision would establish the following time frame for national coverage determinations—6 months when a technology assessment is not required and 9 months when a technology assessment is required and in which a clinical trial is not requested. After the 6- or 9-month period, the draft proposed decision would be available on the HHS website or by other means to provide a 30-day public comment period. The final decision on the request must be made 60 days following the end of the public comment period.	Section 733. Similar provision. The routine costs of care for Medicare beneficiaries participating in clinical trials that are conducted in accordance with an investigational device exemption approved under Section 530(g) of the Federal Food, Drug, and Cosmetic Act would be covered. Also, the Secretary would be required to implement revised procedures for the issuance of temporary national HCPCS codes by January 1, 2004.
Publish annual list of national coverage determinations. The CMS website provides public information about decisions in the national coverage process.	Section 953(b). The Secretary is required to publish an annual list of national coverage determinations made under Medicare in the previous year. Information on how to get more information about the determinations is required to be included in the publication. The list and the	No provision.	Section 953(b). The Secretary would publish an annual list of national coverage determinations made under Medicare in the previous year. Information on how to get more information about the determinations would be included. The list

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<p>Establish pancreatic islet cell transplant demonstration project. No explicit statutory authorization. Under existing authorities, Medicare covers the routine costs of qualifying clinical trials which includes items or services typically provided absent a clinical trial and items or services needed for the diagnosis or treatment of complications. Routine costs include items and services that are typically provided absent a clinical trial (such as conventional care) and needed for reasonable and necessary care (such as diagnosis or treatment of complications) that arises from the provision of an investigational item or service. Medicare does not pay for certain aspects of the clinical trial including: the investigational item or service, items and services not used in the direct clinical management of the patient, and items and services customarily provided by the research sponsor free of charge for any enrollee in the trial.</p>	<p>information is required to be published in an appropriate annual publication that is publically available</p> <p>Section 733. The Secretary, acting through the National Institute of Diabetes and Digestive and Kidney Disorders, is required to conduct a clinical investigation of pancreatic islet cell transplantation which includes Medicare beneficiaries. Beginning no earlier than October 1, 2004, the Secretary is required to pay for the routine costs as well as transplantation and appropriate related items and services for Medicare beneficiaries who are participating in such a trial or a trial investigating organ or tissue transplantation for which the Secretary has made a non-coverage decision.</p>	<p>Section 462. The Secretary would be required to establish a 5-year demonstration project to pay for pancreatic islet cell transplantation and related items and services for Medicare beneficiaries who have type 1 diabetes and end-stage renal disease.</p>	<p>would be published in an appropriate annual publication that is publically available.</p> <p>Section 735. Medicare would be required to pay the routine costs for items and services that beneficiaries receive as part of a clinical investigation of pancreatic islet cell transplants conducted by the National Institute of Health. The transplant would not be covered.</p>
<p>Establish funding for consumer ombudsman The Omnibus Budget Reconciliation Act of 1990 established State Health Insurance Counseling Assistance grants to states to provide education and information to Medicare beneficiaries. Funding has been subject to annual appropriations.</p>	<p>No provision. (A beneficiary ombudsman is established in section 923.)</p>	<p>Section 606. A Consumer Ombudsman Account would be established in the Medicare Trust Fund and \$1 for every Medicare beneficiary would be appropriated to the account from the Trust Fund beginning with fiscal year 2005. The account would be used to make grants to State Health Insurance Counseling Programs.</p>	<p>No provision.</p>
<p>Increase funding for the Health Care Fraud and Abuse Control (HCFAC) Program and the HHS-IG The Health Insurance Portability and Accountability Act of 1996 (HIPAA, PL 104-91) established the HCFAC Program which is administered by the HHS-OIG and the Department of Justice.</p>	<p>No provision.</p>	<p>Section 611. Additional appropriations to HCFAC would be authorized. In FY2004, the increase would be \$10 million over the FY2003 appropriation limit; in FY2005 the increase would be \$15 million over the FY2003 limit; in FY2006 the increase would be \$25 million above the</p>	<p>No provision.</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Funds for the HCFAC program are appropriated from the Federal Hospital Insurance Trust Fund. HIPAA provided for annual increases of 15% in HCFAC funding through 2003, after which the appropriation for HCFAC and the amount earmarked for HHS-OIG remains the same. In FY2003 the available appropriation for HCFAC was \$240,558,320 of which \$150 million to \$160 million was available to the HHS-OIG.		FY2003 limit. Subsequent years' appropriations would be at the 2003 limit. The HHS-OIG earmarked appropriations would increase as well: to \$170 million in FY2004, \$175 million in FY2005, \$185 million in FY2006. In subsequent years, it would be not less than \$150 million and not more than \$160 million.	
Increase the civil monetary penalties in the False Claims Act The False Claims Act imposes a liability on those who knowingly present or cause to be presented a false or fraudulent claim for payment by the government. In certain instances, the person may be liable for a civil penalty of not less than \$5,000 and not more than \$10,000, plus treble damages.	No provision.	Section 612. For violations occurring beginning January 1, 2004, the minimum amount of the civil penalty would be increased from \$5,000 to \$7,500 and the maximum amount would increase from \$10,000 to \$15,000.	No provision.
Increase the civil monetary penalties (CMP) in the Social Security Act OIG has the authority to impose CMPs on any person (including an organization or other entity, but not a beneficiary) who knowingly presents, or causes to be presented, to a state or federal government employee or agent, certain false or improper claims for medical or other items or services. CMPs may also be imposed for other fraudulent activities such as inflating charges or soliciting remuneration to influence the provision of services. Depending upon the violation, Section 1128A of the SSA authorizes CMPs up to \$10,000 for each item or service, up to \$15,000 for individuals who provide false or misleading information in certain instances, and up to \$50,000 per act in other instances as well as treble damages.	No provision.	Section 613. The amount of penalties would be increased for violations that occur beginning January 1, 2004. Penalties that are limited to \$10,000 would be increased to \$12,500; those penalties that are limited to \$15,000 would be increased to \$18,750; and those that are limited to \$50,000 would be increased to \$62,500.	No provision.
Require MedPAC to examine financial consequences associated with its recommendations and other	Section 735. MedPAC is to examine the budgetary consequences of a recommendation before making the recommendation and to review	No provision.	Section 731. MedPAC would be required to examine the budgetary consequences of a recommendation and review the factors

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>requirements. The Medicare Payment Advisory Commission is a 17-member body that reports and makes recommendations to Congress regarding Medicare payment policies. GAO is required to establish a public disclosure system for Commissioners to disclose financial and other potential conflicts of interest.</p>	<p>the factors affecting the efficient provision of expenditures for services in different health care sectors under Medicare fee-for-service. GAO is required to appoint experts in the area of pharmaco-economics or prescription drug benefit programs to MedPAC. In addition, members of the Commission are required to be treated as employees of Congress for purposes of financial disclosure requirements and GAO is required to ensure compliance with this requirement.</p>		<p>affecting the efficient provision of expenditures for services in different health care sectors. Two additional MedPAC reports would be submitted no later than June 1, 2004: the first would study the solvency and financial circumstances of hospitals and other Medicare providers, including uncompensated care accounted for by the treatment of illegal aliens; the second would address investments, capital financing and access to capital of hospitals participating under Medicare. Members of the Commission would be treated as employees of Congress for purposes of financial disclosure requirements.</p>
<p>Change Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. Medicare participating hospitals that operate an emergency room (ER) are required to provide necessary screening and stabilization services to any patient who comes to an ER requesting examination or treatment for a medical condition, in order to determine whether an emergency medical situation exists. Hospitals found in violation of EMTALA may face civil money penalties and termination of their provider agreement.</p>	<p>Section 944. Emergency room services provided to screen and stabilize a Medicare beneficiary furnished after January 1, 2004, are required to be evaluated for Medicare's "reasonable and necessary" requirement on the basis of the information available to the treating physician or practitioner at the time the services were ordered. The Secretary is required to establish a procedure to notify hospitals and physicians when an EMTALA investigation is closed. Except in the case where a delay would jeopardize the health and safety of individuals, the Secretary is required to request a peer review organization (PRO) review before making a compliance determination that would terminate a hospital's Medicare participation because of an EMTALA violation. Other requirements would apply.</p>	<p>No provision.</p>	<p>Section 944. For EMTALA-required services provided to a Medicare beneficiary, determinations about medical necessity would be required to be made on the basis of the information available to the treating physician or practitioner at the time the item or service was ordered or furnished and not on the patient's principal diagnosis. The Secretary would establish a procedure to notify hospitals and physicians when an EMTALA investigation is closed. Except where a delay would jeopardize the health and safety of individuals, the Secretary would be required to request a PRO review before making a determination to terminate a hospital's Medicare participation because of an EMTALA violation. Other requirements would apply.</p>
<p>Establish an EMTALA technical advisory group. No explicit statutory instruction.</p>	<p>Section 945. The Secretary is required to establish a technical advisory group comprised of the CMS Administrator, the HHS-IG of HHS, hospital, physician and patient representatives, CMS staff investigating EMTALA cases and a state survey office representative to review issues related to EMTALA.</p>	<p>No provision.</p>	<p>Section 945. The Secretary would be required to establish a technical advisory group comprised of the CMS Administrator, the HHS-IG of HHS, hospital, physician and patient representatives, CMS staff investigating EMTALA cases and a state survey office</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Permit the Secretary to waive a program exclusion. The Secretary has the authority to waive exclusion from participation in any Federal health program when the provider is the sole source of care in a community, at the request of a state.	Section 949. The Secretary is permitted to waive a program exclusion at the request of an administrator of a federal health care program (which includes state health care programs).	Section 544. The Secretary would be permitted to waive a program exclusion at the request of an administrator of a federal health care program (which includes state health care programs).	representative to review issues related to EMTALA. Section 949. Same provision.

Medicare Demonstration Projects and Studies

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Demonstration Projects			
Establish demonstration project to clarify definition of homebound. A Medicare beneficiary must be confined to the home (or homebound) in addition to other criteria in order to qualify for the home health benefit.	Section 702. A 2-year demonstration project where beneficiaries enrolled in Medicare Part B with a permanent and severe disabling condition and with specified care needs would be deemed to be homebound in order to receive home health services under Medicare. The number of participants is limited to 15,000.	Section 450. The Secretary would establish a 2-year demonstration project where beneficiaries with chronic conditions would be deemed to be homebound in order to receive home health services under Medicare.	Section 704. Same provision.
Establish health care quality demonstration projects. No provision in current law.	Section 646. The Secretary is required to establish a 5-year demonstration program that examines factors that encourage improved patient care quality, including incentives to improve the safety of care; examination of service variation and outcomes measurement; shared decision making between providers and patients; among others. Under this program, certain physician groups, integrated health care delivery systems, or regional coalitions may implement alternative payment systems, streamline documentation and reporting requirements, and offer benefit packages distinct from those currently available under	Section 441. The Secretary would be required to establish a 5-year, budget neutral demonstration program that examines the health delivery factors which encourage the delivery of improved quality patient care.	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
	the Medicare program. This program is subject to budget-neutrality requirements.		
Establish adult day care demonstration project. No provision in current law.	Section 703. A demonstration project is required where a HHA, directly or under arrangement with a medical adult day care facility, will provide medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home.	Section 454. A demonstration project under which a home health agency, directly or under arrangement with a medical adult day care facility, would provide medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home would be established.	Section 732. Same provision.
Establish complex clinical care improvement program. No provision in current law.	Section 721. The Secretary is required to establish and implement chronic care improvement programs for Medicare fee-for-service (not a demonstration). The programs must be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets for Medicare beneficiaries with certain chronic health conditions.	Section 442. The Secretary would be required to establish a 3-year budget neutral demonstration program to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes before October 1, 2004. Six sites would be designated for the demonstration, three in urban areas and at least one in a rural area. One site would be required to be located in Arkansas. The Secretary would pay each principal care physician a monthly management fee developed by the Secretary that would be the full payment for all the functions performed.	Section 721. Chronic care improvement services to certain beneficiaries with chronic conditions would be provided as a Medicare benefit, not a demonstration project.
Establish MA chronic care improvement program. No provision in current law.	Section 722. Each Medicare Advantage organization is required to have an on-going quality improvement program for improving the quality of care provided to enrollees (except for private fee-for-service plans or MSA plans) effective for contract years beginning January 1, 2006. As part of the quality improvement program, each MA organization is required to have a chronic care improvement program. Each chronic care improvement program is required to have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria	Section 443. The Secretary would be required to establish a 5-year, budget neutral demonstration program that uses qualified care management organizations to provide health risk assessment and care management services to high-risk Medicare beneficiaries including those with multiple sclerosis or other disabling chronic conditions, nursing home residents (or those at risk for placement), or high-risk, dual-eligible beneficiaries.	Section 722. Comparable services to beneficiaries in Medicare Advantage and Enhanced FFS would be established as a Medicare benefit, not as a demonstration project.

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	established by the organization for participation under the program.		
Establish frontier extended stay clinic demonstration project. No provision in current law.	Section 434. The Secretary is to conduct a 3-year budget-neutral demonstration project that treats frontier extended stay clinics as Medicare providers. A frontier extended stay clinic is one that is located in a community where the closest acute care hospital or critical access hospital is at least 75 miles away or is inaccessible by public road and is designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or patients who need monitoring and observation for a limited period of time. A report to Congress from the Secretary is due within 1 year of the project's conclusion.	Section 457. The Secretary would conduct a 3-year demonstration project that would treat frontier extended stay clinics as a Medicare provider. A frontier extended stay clinic is one that is located in a community where the closest acute care hospital or critical access hospital is at least 75 miles away or is inaccessible by public road and is designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or patients who need monitoring and observation for a limited period of time. [Duplicate provision at Section 460].	No provision.
Establish chiropractor demonstration project. No specific provision with respect to a demonstration project. Medicare covers limited chiropractic services, specifically manual manipulation for correction of a subluxation.	Section 651. Requires the Secretary to establish a 2-year demonstration project to evaluate the feasibility and advisability of covering additional chiropractic services under Medicare in 4 sites.	Section 440. The Secretary would establish a 3-year budget neutral demonstration program at 6 sites to evaluate the feasibility and desirability of covering additional chiropractic services under the Medicare program.	No provision.
Physical therapy service demonstration project. No provision in current law.	Section 647. MedPAC is required to study the feasibility and advisability of allowing Medicare beneficiaries in fee-for-service direct access to outpatient physical therapy services and those physical therapy services that are furnished as comprehensive rehabilitation facility services. For the purposes of the study, direct access is defined as access to physical therapy services without the requirement that beneficiaries be under the care of, or referred by, a physician. Further, the services provided are not required to be under the supervision of a physician. The study is due by January 1, 2005.	Section 449. The Secretary would be required to establish a budget neutral 3-year demonstration project in at least five states to examine the costs and patient satisfaction associated with allowing Medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and comprehensive outpatient rehabilitation facility (CORF) services. In this instance, the beneficiary would not be required to be under the care of or referred by a physician to receive physical therapy services.	Section 624. The GAO would be required to conduct a study of patient access to physical therapist services in states authorizing such services without a physician referral compared to that in states requiring such referral. The study would be due to Congress within 1 month of enactment.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Establish certified registered nurses as surgical first assistants demonstration project. No provision in current law.	<p>Section 643. MedPAC is required to study the feasibility and advisability of Medicare Part B payment for surgical first assisting services furnished by a certified registered nurse first assistants to Medicare beneficiaries. The report is due by January 1, 2005.</p> <p>Section 644. MedPAC is required to study the practice expense relative values in the Medicare physician fee schedule for the specialty of thoracic surgery to determine whether such values adequately take into account the attendant costs of nurse assistants at surgery. The study is due by January 1, 2005.</p>	Section 450I. The Secretary would be required to conduct a 3-year budget neutral demonstration in five states that would pay for “surgical first assisting services” to Medicare beneficiaries furnished by a certified registered nurse first assistant.	No provision.
Establish weight loss program demonstration project. No provision in current law. Medicare covers medical nutrition therapy services for beneficiaries with diabetes or renal disease who (1) have not received diabetes outpatient self-management training services within a time period to be determined by the Secretary, (2) are not receiving maintenance dialysis, and (3) meet other criteria that will be established. Nutrition therapy services are nutritional diagnostic, therapy, and counseling services for the purpose of disease management. The services must be provided by a registered dietitian or nutritional professional pursuant to a referral by a physician. Payment is based on the lower of actual charges or 85% of the physician fee schedule on an assignment-related basis.	No provision.	Section 450L. The Secretary would be required to establish a demonstration project that would provide group weight loss management services for Medicare beneficiaries who are obese and have impaired glucose tolerance and who have been diagnosed and referred by a physician for assessment and treatment based on individual needs to a specific program or method that has demonstrated efficacy to produce and maintain weight loss through results published in peer-reviewed scientific journals. Services include current body weight measurement and recording of weight status at each meeting session; provision of a healthy eating plan; provision of an activity plan; provision of a behavior modification plan; and a weekly group support meeting.	No provision.
Extend the telehealth project at Columbia University consortium. BBA 1997 established a single 4-year demonstration project where an eligible health care provider telemedicine network would use high-capacity computer systems and medical informatics to improve primary	Section 417. The demonstration project will be extended for 4 years and total funding will be increased from \$30 million to \$60 million.	No provision.	Section 415. The demonstration project would be extended for 4 years and total funding would be increased from \$30 million to \$60 million.

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care and prevent health complications in Medicare beneficiaries with diabetes mellitus.			
<p>Extend the municipal demonstration projects Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, the Municipal Health Service Demonstration projects will expire on December 31, 2004. The project is a multi-site demonstration intended to improve access to primary care services in underserved urban areas and to reduce the cost of health care. BBA 1997 authorized the Secretary to extend the project through December 31, 2000, but only with respect to persons who had received at least one service for the period of January 1, 1996-August 7, 1997 (the enactment date of BBA 97). Sites that wanted the demonstration project extended were required to submit plans for the orderly transition of participants to a non-demonstration health care delivery system. Subsequent legislation extended the project through December 31, 2004.</p>	No provision.	<p>Section 618. Demonstration projects would be extended until December 31, 2006, for individuals who reside in the city in which the project is operated.</p>	<p>Section 236. Demonstration projects would be extended until December 31, 2009, for individuals who reside in the city in which the project is operated.</p>
<p>Establish consumer directed chronic outpatient services demonstration project. No provision. Medicare coverage requires that a beneficiary need medically necessary care. In general, Medicare pays the provider that delivers skilled health care services.</p>	<p>Section 648. The Secretary is required to establish no fewer than 3 demonstration projects that evaluate methods to improve the quality of care provided to Medicare beneficiaries with chronic conditions and that reduce expenditures that would otherwise be made on their behalf by Medicare. The methods are required to include permitting beneficiaries to direct their own health care needs and services. In designing the demonstrations, the Secretary is required to evaluate practices used by group health plans and practices under State Medicaid programs that permit patients to self-direct the provision of personal care services and to determine the appropriate scope of personal care services that apply under the demonstration projects.</p>	No provision.	<p>Section 736. The Secretary would establish no fewer than three demonstration projects to evaluate method to improve the care and reduce the cost of care provided to Medicare beneficiaries with chronic conditions including methods that would permit beneficiaries to direct their own health care needs and services. The Secretary would establish the demonstrations located in an urban area, a rural area, and an area that has a Medicare population with a diabetes rate that significantly exceeds the national average rate within 2 years of enactment. The Secretary would evaluate and submit reports to Congress on the cost and clinical effectiveness of the projects biannually beginning 2 years after their start.</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Required Studies			
Require MedPAC study on home health agency (HHA) margins No provision in current law.	Section 705. MedPAC is required to study payment margins of HHAs paid under PPS, to examine whether systematic differences in payment margins are related to differences in case mix, as measured by home health resource groups (HHRGs), among agencies.	No provision.	Section 703. MedPAC would study payment margins of home health agencies paid under PPS to examine whether systematic differences in payment margins were related to differences in case mix, as measured by HHRGs.
Require Institute of Medicine (IOM) report related to chronic conditions No provision in current law.	No provision.	No provision.	Section 723. The Secretary would contract with the IOM to study the barriers to effective integrated care improvement for Medicare beneficiaries with multiple or severe chronic conditions across settings and over time. The study would examine the statutory and regulatory barriers to coordinating care across settings for Medicare beneficiaries in transition from one setting to another.
Require MedPAC report related to chronic care improvement program No provision in current law.	No provision.	No provision.	Section 724. MedPAC would evaluate the chronic care improvement program established in Section 721. The evaluation would include a description of the status of the implementation of the program, the quality of health care services provided to individuals participating in the program, and the cost savings attributed to the implementation of the program.
Require GAO study on impact of assets test on low-income beneficiaries. No provision in current law.	Section 107(e). GAO is required to determine the extent to which drug utilization and access to covered drugs differs between: (1) individuals who qualify as subsidy eligible individuals, and (2) individuals who do not qualify for this type of assistance solely because of an assets test. The final report (including recommendations for legislation) is due no later than September 30, 2007.	Section 607. GAO would determine the extent to which drug utilization and access to covered drugs differs between: (1) individuals who qualify for the transitional assistance prescription drug card program or for subsidies available to certain low-income beneficiaries and (2) individuals who do not qualify for these types of assistance solely because of an assets test to the income eligibility requirements of such individuals. The final report (including recommendations for legislation) would be due no later than September 30, 2007.	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Require MedPAC study on Medicare payments and efficiencies in the health care system No provision in current law.	No provision.	Section 455. MedPAC is required to recommend to Congress ways to recognize and reward the practice of medicine in historically efficient and low-cost areas. The recommendations would be made within established Medicare payment methods for hospitals and physicians.	No provision.

Beneficiary Issues: Cost-Sharing Amounts and Provision of Information

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Beneficiary Cost-Sharing Amounts			
Indexing Part B deductible to inflation. Under Part B, Medicare generally pays 80% of the approved amount for covered services after the beneficiary pays an annual deductible of \$100. The Part B deductible has been \$100 since 1991.	Section 629. The Medicare Part B deductible will remain \$100 through 2004. The deductible will be \$110 for 2005, and in subsequent years the deductible will be increased by the same percentage as the Part B premium increase, rounded to the nearest dollar.	Section 433. The Medicare Part B deductible would be set at \$100 through 2005 and then increased to \$125 in 2006. Effective January 1 of subsequent years, the deductible would be increased annually by the percentage change in the CPI-U for the previous year ending in June. The amount would be rounded to the nearest dollar.	Section 628. Starting January 1, 2004, the Medicare Part B deductible would be increased by the same percentage as the Part B premium increase. Specifically, the annual percentage increase in the monthly actuarial value of benefits payable from the Federal Supplementary Medical Insurance Trust Fund would be used as the update. The amount would be rounded to the nearest dollar.
Income-relating the Part B premium. Beneficiaries pay a monthly Part B premium equal to 25% of program costs. The remaining 75% is financed from federal general revenues. The premium amount is the same for all enrollees. In general, the premium amount is subtracted from the beneficiary's social security check. A beneficiary's social security check can not go down from one year to the next as a result of the annual Part B premium increase.	Section 811. The Part B premiums for higher income enrollees will be increased beginning in 2007. Individuals whose modified adjusted gross income exceeds \$80,000 and couples filing joint returns whose modified adjusted gross income exceeds \$160,000 will be subject to higher premium amounts. The increase will be calculated on a sliding scale basis and be phased-in over a five-year period. The prohibition against a drop in an individual's social security check will not apply to this population group.	No provision.	No provision.
Waive Part B enrollment fee for certain Medicare beneficiaries who are military retirees. A late enrollment penalty	Section 625. The late enrollment penalty is waived for certain military retirees who enrolled in part B during 2001, 2002, 2003,	Section 439. Beginning January 2005, the late enrollment penalty would be waived for certain military retirees who enrolled in Part B during,	

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
is required to be imposed on beneficiaries who do not enroll in Medicare part B upon becoming eligible for Medicare.	or 2004. The Secretary is required to provide a special Part B enrollment period for these military retirees beginning as soon as possible after enactment and ending December 31, 2004. The provision applies to premiums for months beginning January 2004. The Secretary is required to rebate premium penalties paid for months on or after January 2004 for which a penalty does not apply as a result of this provision, but for which a penalty was collected.	2002, 2003, 2004 or 2005 and a special enrollment period, beginning 1 year after enactment and ending December 31, 2005, would be provided. Section 627. Similar provision, except that the waiver would apply beginning January 1, 2004, and the special enrollment period would begin as soon as possible after enactment and end December 31, 2004.	
Establish beneficiary cost-sharing for home health services. The home health benefit does not have any cost-sharing requirement.	No provision.	No provision.	Section 702. A beneficiary copayment for each 60-day episode of care beginning January 1, 2004 would be established. The copayment amount would be 1.5% of the national average payment per episode in a calendar year, rounded to the nearest multiple of \$5. For 2004, the copayment would be \$40 unless otherwise calculated on a timely basis by the Secretary. Medicare payments would be reduced to reflect copayments. Qualified Medicare beneficiaries, beneficiaries dually eligible for Medicare and Medicaid, and beneficiaries receiving four or fewer home health visits in an episode of care would not face any cost-sharing requirements. Administrative and judicial review of the calculated copayment amounts would be prohibited.
Establish beneficiary cost-sharing for clinical diagnostic services not provided by a sole community hospital. Medicare pays laboratories directly for laboratory services provided to ambulatory patients in an outpatient setting. Clinical lab services are paid on the basis of area-wide fee schedules. The fee schedule amounts are periodically updated. Assignment is mandatory. No beneficiary cost-sharing is imposed.	No provision.	Section 431. Beginning January 1, 2004, Medicare would pay all clinical laboratories 80% of the applicable fee schedule amount. Hospital-based, physician office and independent laboratories would be able to charge beneficiaries a 20% coinsurance amount. The Medicare Part B deductible would apply to clinical diagnostic laboratory tests furnished across all settings. SCHs would be exempt from this provision. (see Section 427).	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Waive deductible for colorectal cancer screening tests. Unless otherwise specified, Part B services are subject to beneficiary cost-sharing amounts, including an annual deductible and coinsurance amount.	No provision.	No provision.	Section 613. The Part B deductible would be waived for colorectal cancer screening tests.
Provision of Information to Beneficiaries			
Include additional information in notices to beneficiaries about SNF and hospital benefits. Although the statute requires that beneficiaries receive a statement listing the items and services for which payment has been made, there is no explicit statutory instruction that requires the notice to include information about the number of days of coverage remaining in either the hospital or SNF benefit.	Section 925. Beneficiary notices for those beneficiaries in SNFs are required to include information about the number of days of coverage remaining under the SNF benefit and the spell of illness involved.	Section 551. Beneficiary notices for those beneficiaries in SNFs and hospital would be required to include information about the number of days of coverage remaining under the SNF benefit and the spell of illness involved.	Section 925. Similar provision. Would require information for beneficiaries in a SNF stay only.
Provide information on Medicare-certified SNF in hospital discharge plans. The hospital discharge planning process requires evaluation of a patient's likely need for post-hospital services including hospice and home care.	Section 926. The Secretary is required to make information publicly available regarding whether SNFs are participating in the Medicare program. Hospital discharge planning is required to evaluate a patient's need for SNF care.	Section 552. The Secretary would be required to make information publicly available regarding whether SNFs were participating in the Medicare program. Hospital discharge planning would be required to include evaluating a patient's need for SNF care.	Section 926. Same provision.
Require information on advance directives. Information about advance directives is required to be given to patients in hospitals, skilled nursing facilities, and served by home health agencies. The Secretary is required to provide Medicare beneficiaries annual information about Medicare benefits, limitations on payment, and a description of the limited benefits for long-term care. This information is provided to Medicare beneficiaries in the <i>Medicare and You</i> handbook that is mailed annually to all beneficiaries.	No provision.	Section 616. The Secretary would be required to provide information on advance directives in the <i>Medicare and You</i> handbook. The information would be required to be presented in a separate section on advance directives and would include specific information about living wills and durable power of attorney for health care. The Secretary would further be required to note the inclusion of this information in the introductory letter that accompanies the handbook.	No provision.
Require OIG report on notices concerning use of hospital lifetime reserve days. No provision in current law.	No provision.	No provision.	Section 953(d). The OIG would report to Congress on the extent to which hospitals provide notice to Medicare beneficiaries, in

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
			accordance with applicable requirements, before they use the 60 lifetime reserve days under the hospital benefit as well as the appropriateness and feasibility of hospitals providing a notice to beneficiaries before they exhaust the lifetime reserve days. The report would be due no later than 1 year after enactment.

Other Health-Related Studies, Commissions or Committees

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Pay emergency health services provided to undocumented aliens BBA 1997 provided \$25 million in funding for state emergency health services furnished to undocumented aliens for each of FY1998 through 2001. Funds were distributed among the 12 states with the highest number of undocumented aliens. In a fiscal year, each state's portion of the total funds available was based on its share of total undocumented aliens in all of the eligible states based on the estimates provided by the Immigration and Naturalization Service (INS).</p>	<p>Section 1011. The bill appropriates \$250 million in additional federal funding for emergency health services furnished to undocumented aliens for each year from FY2005-FY2008. Of this amount, \$167 million will be allocated among eligible providers in all states according to a specified formula, the remaining money will be distributed among eligible providers in the six states with the highest number of undocumented alien apprehensions for such fiscal year according to a specified formula.</p> <p>From the \$250 million in state allotments described above, the Secretary will pay directly to eligible providers for unreimbursed costs incurred by providing emergency health care services during that fiscal year to certain specified groups of undocumented aliens. The Secretary shall determine the payment amount for each eligible provider and if necessary will reduce the amount of payment to eligible providers to ensure that each eligible provider is paid. Other provisions would also apply and funds will remain available until they are expended.</p>	<p>Section 610. \$250 million in additional federal funding for emergency health services furnished to undocumented aliens would be appropriated for each year from FY2005-FY2008. Of this amount, \$167 million would be allocated among all states according to a specified formula, the remaining money would be distributed to the six states with the highest number of undocumented alien apprehensions for such fiscal year according to specified formulas. Other provisions would apply.</p>	<p>No provision.</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
	The provision will be effective upon enactment.		
Commission of systematic interoperability. No provision in current law.	Section 1012. The Secretary is required to establish a Commission on Systemic Interoperability to develop a comprehensive strategy for the adoption and implementation of health care information technology standards. Members of the Commission are to be appointed by the President, the Senate Majority and Minority Leaders, and the House Speaker and Minority Leader. In developing its strategy, the Commission must consider the costs and benefits of the standards, the current demand on industry resources to implement these and other electronic standards (including the HIPAA Administrative Simplification standards), and the most cost-effective and efficient means for industry to implement the standards. Not later than October 31, 2005, the Commission must submit a report to the Secretary and the Congress describing its strategy. The Commission shall terminate 30 days after submitting its report to the Secretary and the Congress. The bill authorizes to be appropriated such sums as may be necessary to carry out this Section.	No provision.	No provision.
Research on outcomes of health care items and services. The Agency for Healthcare Research and Quality (AHRQ) is an agency within the Department of Health and Human Services. AHRQ's mission is to support, conduct, and disseminate research that improves access to care and the outcomes, quality, cost, and utilization of health care services.	Section 1013. The bill authorizes and appropriates \$50 million for the Secretary through the Agency for Healthcare Research and Quality to conduct research to address the scientific information needs and priorities identified by the Medicare, Medicaid, and State Children Health Insurance Programs. The information needs and priorities will relate to the clinical effectiveness and appropriateness of specified health services and treatments, and the health outcomes associated with such services and treatments. The needs and priorities also will address	No provision.	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
	strategies for improving the efficiency and effectiveness of those health care programs.		
Express sense of the Senate that the Senate Finance Committee should hold meeting to monitor the implementation of this legislation. No provision in current law.	No provision.	Section 617. The provision expresses a sense of the Senate that the Committee on Finance should hold at least four hearings to monitor implementation of the Prescription Drug and Medicare Improvement Act of 2003. The first hearing should be held within 60 days after enactment of the Act, the remaining hearings should be held May 2004, October 2004, and May 2005.	No provision.
Require study on making prescription drug information accessible to the sight impaired. No provision in current law.	No provision.	Section 619. The Secretary would study how to make prescription drug information, including drug labels and usage instructions, accessible to blind and visually impaired individuals with a report due within 18 months of enactment.	No provision.
Establish citizens' health care working group. No provision in current law.	Section 1014. The bill authorizes the Secretary of HHS, acting through the Agency for Healthcare Research and Quality, to establish a group called the "Citizens' Health Care Working Group." The 15-member group will include the Secretary and individuals appointed by GAO. The Working Group will hold hearings and produce public reports about expanding coverage options, the cost of health care, innovative state and community strategies to expand coverage or reduce costs, and the role of evidence-based medicine and technology in improving quality and lowering costs. In addition to hearings, the Working Group will hold community meetings and develop recommendations on health care coverage, and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings.	Section 620. The Secretary would use the Agency for Healthcare Research and Quality to establish a 25-member Citizens' Health Care Working Group. This group would be appointed by Congressional leaders to provide recommendations on ways to improve and strengthen health care coverage and the health care system.	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Require GAO report on price controls in different countries. No provision in current law.	No provision.	Sections 621. GAO would study pharmaceutical price controls in France, Germany, Italy, Japan, the United Kingdom, and Canada and review their impact on consumers, including American consumers, as well as on medical innovations. [Duplicate of Section 634]	No provision.
Establish Safety Net Advisory Commission. No provision in current law.	No provision.	Section 624. The Safety Net Organizations and Patient Advisory Commission would be established to conduct an ongoing review of the health care safety net programs including Medicaid, the State Children's Health Insurance Program (SCHIP), and Maternal and Child Health Services Block Grant Programs, among other programs and payments. The appointment process would be similar to that for MedPAC. Annual reports would be required. [Duplicate of Section 635]	No provision.
Establish Committee on Drug Compounding. No provision in current law.	No provision.	Section 626. The Secretary would establish a committee on Drug Compounding within the FDA to ensure that patients are receiving necessary, safe, and accurate dosages of compounded drugs. Members would be appointed by the Secretary and would include representatives from associations, advocates and other interested parties. The Committee would submit a report with recommendations to improve and protect patient safety within 1 year of enactment whereupon the Committee would terminate.	No provision.
Express sense of Senate regarding structure of Medicare reform. No provision in current law.	No provision.	Section 627. The provision provides a sense of the Senate that Medicare reform should be developed according to nine principles. For instance, prescription drug coverage should be directed to those who need it most; should incorporate private sector market based elements; should cost no more than \$400 billion; and should preserve employer sponsored retiree plans among other things.	No provision.

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Express sense of Senate regarding establishment of national lifestyle modification program. The Medicare Lifestyle Modification Demonstration Program has been operating in 12 states.	No provision.	Section 628. The provision provides a sense of the Senate that coronary disease is expensive, the Medicare Lifestyle Modification Program has been operating in 12 states as a demonstration program, and this program of behavior modification should be conducted on a national basis for those beneficiaries who elect to participate.	No provision.
Emphasize employer flexibility in providing health coverage for retirees. No provision in current law.	No provision.	Section 631. The provision allow employers to provide different health insurance benefits to various groups of their retirees, without being in violation of the Age Discrimination and Employment Act (ADEA).	No provision.
Expand responsibilities of the Office of Rural Health Policy (ORHP) in HHS ORHP advises the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the Medicare and Medicaid programs on the financial viability of small rural hospitals, the ability of rural areas to attract and retain physicians and other health professionals, and access to and the quality of health care in rural areas. In addition to advising the Secretary, the Office has other responsibilities including coordinating the activities within HHS that relate to rural health care.	No provision.	Section 637. The list of explicit responsibilities of the Office is expanded to include administering grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.	No provision.

Medicaid and State Children's Health Insurance Program (SCHIP) Provisions

Provisions	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Increase Medicaid disproportionate share hospital (DSH) allotments Hospitals that serve a large number of uninsured patients and Medicaid enrollees receive additional Medicaid disproportionate	Section 1001(a). The bill establishes a temporary increase in DSH allotments for FY2004 and for certain subsequent fiscal years. Allotments for FY2004 are to be set at 116% of FY2003 allotments as under BIPA	Section 601. The special DSH rule established by BIPA that raised DSH allotments, subject to the current law limit of 12% of spending for medical assistance, will be extended for FY2004 and FY2005.	Section 1001. Temporary increase in DSH allotments, subject to the current law limit of 12% of spending for medical assistance, would be established for FY2004 and for certain subsequent fiscal years. Allotments for

Provisions	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
share hospital (DSH) payments. BBA 1997 capped the federal share of Medicaid DSH payments at specified amounts for each state for FY1998 through FY2002. For most states, those specified amounts declined over the 5-year period. A state's allotment for FY2003 and for later years is equal to its allotment for the previous year increased by the percentage change in CPI-U for the previous year. In addition, each state's DSH payment for FY2003 and subsequent years is limited to no more than 12% of spending for medical assistance in each state for that year. BIPA provided states with a temporary reprieve from the declining allotments by establishing a special rule for the calculation of DSH allotments for 2 years, raising allotments for FY2001 and for FY2002. The provision also clarified that the FY2003 allotments were to be calculated as specified above, using the lower, pre-BIPA levels for FY2002 in those calculations.	and will not be subject to the ceiling capping states' allotments at 12% of medical assistance payments. Allotments for subsequent years will be equal to the allotments for FY2004 unless the Secretary determines that the allotments as would have been calculated prior to the enactment of this bill would equal or no longer exceed the FY2004 amounts. For such fiscal years, allotments will be equal to allotments for the prior fiscal year increased by the percentage change in the consumer price index for all urban consumers for the previous fiscal year. The provision is effective upon enactment.	Allotments for FY2004 will be calculated to be equal to FY2004 allotments as established by BBA 1997 increased by the product of 0.50 and the difference between: (a) FY2002 allotments as established by BIPA 2000 increased by the percentage change in the CPI-U for each of fiscal years 2002 and 2003, and (b) FY2004 allotments as established by BBA 1997. Allotments for FY2005 will be calculated to be equal to FY2005 allotments as established by BBA 1997 increased by the product of 0.50; and the difference between: (a) FY2002 allotments as established by the BIPA 2000 increased by the percentage change in the CPI-U for each of fiscal years 2002, 2003, and 2004, and (b) FY2005 allotments as established by BBA 1997. For FY2006 and thereafter , DSH allotments will be calculated based on the previous years' amount as established by BBA 1997 and subject to the current law limit of 12% of spending for medical assistance increased by the CPI-U for the previous fiscal year. All allotments would be subject to the existing limit of 12% of medical assistance spending. A separate calculation of the DSH allotment for the District of Columbia for FY2004 would be specified.	FY2004 would be set at 120% of FY2003 allotments as under BIPA. Allotments for subsequent years would be equal to the allotments for FY 2004 unless the Secretary determines that the allotments as would have been calculated prior to the enactment of this bill would equal or exceed the FY 2004 amounts. For such fiscal years, allotments would be equal to allotments for the prior fiscal year increased by the CPI-U for the previous fiscal year.
Increase in floor for state with low DSH allotments. Extremely low DSH states are those states whose FY1999 federal and state DSH expenditures (as reported to CMS on August 31, 2000) are greater than zero but less than 1% of the state's total medical assistance expenditures during that fiscal year. DSH allotments for the extremely low DSH states for FY2001 were equal to 1% of the state's total amount of expenditures under their plan for such assistance during that fiscal year. For subsequent fiscal years, the allotments for extremely low DSH states	Section 1001(b). Allotments for low DSH states for FY2004 and subsequent years will be increased. For states with DSH expenditures for FY2000 (as reported to CMS as of August 31, 2003) that were greater than zero but less than 3% of the state's total medical assistance expenditures during that fiscal year, the provision would raise the DSH allotments for FY2004 by 16% over the state's allotment for fiscal year 2003. For each of FY 2005 through 2008, those states would receive allotments that are increased by 16% over the previous year's	Section 602. Allotments for certain extremely low DSH states for FY2004 and FY2005 would be increased. For states with DSH expenditures for FY2000 (as reported to CMS as of August 31, 2003) that are greater than zero but less than 3% of the state's total medical assistance expenditures during that fiscal year, the provision would raise the DSH allotments for FY2004 to 3% of the state's total amount of expenditures for such assistance during that fiscal year. States with expenditures for FY2001 (as reported to CMS as of August 31, 2004) that	No provision.

Provisions	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
would be equal to their allotment for the previous year, increased by the percentage change in the CPI-U for the previous year, subject to a ceiling of 12% of that state's total medical assistance payments in that year.	amount. For FY 2009 and all subsequent fiscal years, DSH allotments for those states will be equal to the prior year's amount increased by inflation as for all other states.	are greater than zero but less than 3% of the state's total medical assistance expenditures during that fiscal year would have the DSH allotments for FY2005 equal to such state's DSH allotment for FY2004 increased by the percentage change in the CPI-U for FY2004. A special DSH allotment for Tennessee would be specified in FY2004 and FY2005 under certain circumstances.	
Allotment adjustment. No provision in current law.	Section 1101(c). The bill establishes a contingent DSH allotment for states for fiscal years 2004 and 2005 that have a statewide waiver under section 1115 that is revoked or terminated before the end of either fiscal year and that have an allotment of zero under current law. The provision would permit the state to submit an amendment to its state plan describing the methodology to identify DSH hospitals and to make payments to those hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities, on the basis of their proportion of patients that are low-income with special needs. The provision directs the Secretary of HHS to compute a DSH allotment for the state that provides for an appropriate amount subject to the current law limit of 12% of medical assistance payments, and up to a ceiling such that Medicaid spending in the state would not exceed the spending that would have been made if such waiver had not been revoked or terminated. In determining the amount of an appropriate DSH allotment, the Secretary shall take into account the level of DSH spending for the State for the fiscal year preceding the year in which the waiver commenced.	No provision.	No provision.
Increase DSH reporting requirements BBA 1997 required each state to submit to the Secretary an annual report describing the	Section 1001(d). As a condition of receiving federal Medicaid payments for FY2004 and each fiscal year thereafter, states are required	Section 603. As a condition of receiving federal Medicaid payments for FY2004 and each fiscal year thereafter, the provision	No provision.

Provisions	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
disproportionate share payments made to each disproportionate share hospital (DSH) and the methodology used by the state for prioritizing payments to such hospitals.	to submit to the Secretary an annual report (for the previous fiscal year) identifying each disproportionate share hospital that received a payment, the amount such hospital received, as well as other information the Secretary determines necessary to ensure the appropriateness of the DSH payments for the previous fiscal year. In addition, states are required to submit annually to the Secretary an independent certified audit verifying: the extent to which hospitals receiving DSH payments have reduced their uncompensated care costs to reflect DSH payments received; the states' compliance with the hospital-specific payment ceilings; the methodology used to calculate those ceilings; and the documentation maintained by the states regarding claimed costs, expenditures and payments under this section. The provision is effective upon enactment.	would require each state to submit to the Secretary an annual report (for the previous fiscal year) identifying each disproportionate share hospital that received a payment, the amount such hospital received, as well as other information the Secretary determines necessary to ensure the appropriateness of the DSH payments for the previous fiscal year.	
Clarification regarding non-regulation of transfers States are required to provide not less than 40% of the non-federal share of matching funds toward their Medicaid expenditures. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) prohibited the use of health care related taxes that were not broad based, and certain provider-related donations for the purpose of claiming federal matching payments. The law also limits HHS' authority to restrict a state's inclusions of tax-derived funds transferred from or certified by different levels of governments or governmental entities to the state government as the state's share of Medicaid funding.	Section 1001(e). The provision clarifies that the non-federal share of Medicaid funds transferred from, or certified by a specified publically-owned regional medical center may be used as the non-federal share of Medicaid expenditures as long as the Secretary determines that such donations are proper and in the interest of the Medicaid program. The provision targets, but is not limited to a medical center located in Memphis, Tennessee, and that meets certain other specified criteria. This provision is effective for the period between enactment and December 31, 2005.	No provision.	No provision.
Exempt prices of drugs provided to certain safety net hospitals from Medicaid best price drug program Medicaid drug rebates are calculated based	Section 1002. The definition of "best price" is modified for the purpose of calculating Medicaid drug rebates, to also exclude the discounted inpatient drug prices charged to	Section 604. Effective October 1, 2003, the definition of "best price" for the purpose of calculating Medicaid drug rebates, would be modified to also exclude the discounted	Section 1002. Effective on the date of enactment, the definition of "best price" for the purpose of calculating Medicaid drug rebates, would be modified to also exclude

Provisions	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
on the difference between the Average Manufacturer's Price and the manufacturer's "best price". In determining a drug's best price, certain discounted prices and fee schedules are excluded. Discounted prices for outpatient drugs negotiated by the Office of Pharmacy Affairs (of HHS) with drug manufacturers on behalf of certain clinics and safety net providers are one example of such exclusion. Because of this exclusion, the discounts available to safety net providers have no bearing on the calculation of Medicaid drug rebates which allows those providers to negotiate better rates with manufacturers—since Medicaid rebates will not change with the size of their negotiated discounts. Discounted prices for inpatient drugs for many safety net providers, however, are included in the Medicaid best price.	certain public safety net hospitals. Those hospitals will also be subject to the same auditing and record keeping requirements as other providers with similar exemptions from Medicaid's "best price" determination. The provision is effective upon enactment.	inpatient drug prices charged to certain public safety net hospitals. Those hospitals would also be subject to the same auditing and record keeping requirements as other providers with similar exemptions from Medicaid's "best price" determination.	the discounted inpatient drug prices charged to certain public safety net hospitals. Those hospitals would also be subject to the same auditing and record keeping requirements as other providers with similar exemptions from Medicaid's "best price" determination.
Assist legal immigrants in Medicaid and SCHIP programs "Qualified aliens" who entered the United States after enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, Aug. 22, 1996) are not eligible to receive federally funded benefits under Medicaid or SCHIP for 5 years. Qualified aliens who entered the United States prior to the enactment of PRWORA are eligible for federally funded Medicaid coverage at state option, as are qualified aliens arriving after Aug. 22, 1996 who have been present in the United States for more than 5 years. A person who executed an affidavit of support for an alien under Section 213A of the Immigration and Nationality Act (INA) is liable to reimburse the federal or state government for the public benefits received by the sponsored alien until the alien naturalizes or has accumulated 40 quarters of	No provision.	Section 605. The provision would lift the 5-year ban and would allow states the option to provide medical assistance to certain lawfully residing individuals under Medicaid (including under a waiver authorized by the Secretary) or SCHIP for any of fiscal years 2005 through 2007. Those eligible would include lawfully residing women during pregnancy and the 60-day period after delivery, and children otherwise eligible for Medicaid or SCHIP as defined by the state plan. States opting to provide coverage to such lawfully residing individuals under SCHIP must also provide coverage to such individuals under Medicaid. If services are provided under the Medicaid program, the alien's sponsor would not be liable to reimburse the federal or state government for the cost of such services.	No provision.

Provisions	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
work. Section 213A was enacted as a part of PRWORA on Aug. 22, 1996.			
Extend special DSH treatment for certain urban providers. Hospital-specific limits on DSH payments as well as overall state-wide DSH allotments have been established. DSH payments to hospitals are limited to some percentage of each hospital's costs of providing inpatient and outpatient services to Medicaid and uninsured patients net of payments received from or on behalf of these patients ("unreimbursed costs"). DSH payments to public hospitals are limited to 100% of unreimbursed costs except in FY2003 and FY2004 when that limit rises to 175% of unreimbursed costs. DSH payments to private hospitals are limited to 100% of these costs; certain public hospitals in California have a permanent DSH limit of 175%.	No provision.	Section 625. DSH payments made to hospitals that are owned and operated by the state of Indiana and located in Marion County would be made without regard to the state's DSH allotment limitation so long as those payment amounts, for FY2004 and each fiscal year thereafter do not exceed 175% of the "unreimbursed costs" of furnishing hospital services.	No provision.
Increase Medicaid payments for certain Hawaiian providers. The Medicaid program is jointly financed by the states and the federal government with the federal government share based on each state's federal medical assistance percentage (FMAP). The FMAP for a state is calculated using a formula designed to give a higher FMAP to states with a per capita income below the U.S. average. No state can have an FMAP of less than 50% or more than 83%. Certain services including family planning are paid at alternative FMAP rate, as are administrative expenses. In addition, certain services provided through an Indian Health Service facility, Indian tribe or organization have an FMAP of 100%. The Jobs and Growth Tax Relief Reconciliation Act of 2003 (JEGTRRA, P.L. 108-026) altered the statutory calculation of the FMAPs by providing a hold harmless for declines from the prior year for each	No provision.	Section 632. For services provided to a Native Hawaiian by a federally qualified health center or a Native Hawaiian health care system, the FMAP would be 100%. Services qualifying for the 100% FMAP would include those provided by referral, and under contract or other arrangement between a health care provider and the federally qualified health center or Native Hawaiian health care system.	No provision.

Provisions	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
state FMAP, and a temporary increase of 2.95 percentage points for the last two quarters of fiscal year 2003 and the first three quarters of fiscal year 2004. The calculated statutory FMAPs for Hawaii would be 58.77% for fiscal year 2003 and 58.90% for fiscal year 2004. The JEGTRRA changes result in an FMAP for Hawaii of 61.75% for the last two quarters of fiscal year 2003, and 61.85% for the first three quarters of fiscal year 2004. The FMAP for services provided to a Native Hawaiian is the same as for services provided to other Medicaid beneficiaries in Hawaii.			
Extend special treatment for a specific provider Medicaid payment for services provided by an institution for mental disease (IMD) may be made only for beneficiaries who are under age 21 or over 65. IMD means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. For two facilities in Michigan—Kent Community Hospital Complex and Saginaw Community Hospital—previous legislation has imposed a moratorium on determination of the facilities as IMDs through December 31, 2002.	Section 1003. The moratorium on the determination of Saginaw Community Hospital as an IMD is permanently extended as if this provision were included in Section 4758 of the Balanced Budget Act of 1997 (BBA 1997).	Section 633. The moratorium on the determination of Saginaw Community Hospital as an IMD would be permanently extended as if included in BBA 1997.	No provision.

Cost Containment and Miscellaneous Financial Provisions

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
Status of Medicare trust funds in annual trustees report. The Medicare Board of Trustees was established under the Social Security Act to oversee the financial operations of the Medicare Hospital	Section 801. Beginning with the 2005 report, the Trustees annual report is required to include a determination whether there is projected to be “excess general revenue Medicare funding” for the fiscal year	Section 131. The Trustees would be required to submit a combined report on the status of the two trust funds including the Prescription Drug Account. The report would include a statement of the total	The Trustees would be required to submit a combined report on the status of the two trust funds and the Prescription Drug Trust Fund. The report would include a statement of the total amounts obligated during the

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>Insurance (HI) trust fund and the Medicare Supplementary Medical Insurance (SMI) trust fund. The Trustees are required to submit annual reports to the Congress.</p>	<p>or any of the succeeding 6 fiscal years. Excess general revenue Medicare funding is when general revenue Medicare funding expressed as a percentage of total Medicare outlays for the fiscal year exceeds 45%. When excess general revenue funding of Medicare is projected for 2 consecutive annual reports this is to be treated as a “funding warning” for the purpose of requiring the President to submit legislation to Congress.</p> <p>Section 802. The President is required to submit proposed legislation to Congress to respond to the warning of excess general revenue funding of Medicare within specified timeframes.</p> <p>Section 803. The provision sets out the procedures for House consideration of the President’s legislative proposal.</p> <p>Section 804. The provision provides for some limited special procedures in the Senate for consideration of legislation arising from the Trustees determination of excess general revenue Medicare funding.</p>	<p>amounts obligated during the preceding fiscal year from the General Revenues of the Treasury and the percentage such amount bore to all other obligations of the Treasury in that year.</p> <p>Section 132. The 2004 reports would be required to include an analysis of the total amount of unfunded obligation of Medicare. The analysis would compare long-term obligations, including the combined obligations of the HI and SMI trust funds, to the dedicated funding sources for the program (not including transfers of general revenue)</p>	<p>preceding fiscal year from the General Revenues of the Treasury for payment of benefits and the percentage such amount bore to all other general revenue obligations of the Treasury in that year.</p>
<p>Extend authority to collect Customs fees The U.S. Customs Service, the federal government’s oldest revenue collecting agency is responsible for regulating the movement of persons, carriers, merchandise, and commodities between the United States and other countries. Its authority to impose user fees for certain services lapsed on September 30, 2003.</p>	<p>No provision.</p>	<p>Section 614. The authority would be extended until September 30, 2013.</p>	<p>No provision.</p>
<p>Require the Internal Revenue Service (IRS) to deposit certain receipts The Secretary of the Treasury was granted the authority by Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-286, the Treasury, Postal Service and General Government Appropriations Act of 1995 to establish new</p>	<p>No provision.</p>	<p>Section 450G. The Secretary of the Treasury must deposit any fees collected under the authority provided by Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-286, the Treasury, Postal Service and General Government Appropriations Act of 1995 into the Treasury as miscellaneous receipts. The</p>	<p>No provision.</p>

Provision and Current Law	H.R. 1 as enacted	S. 1 (as passed the Senate)	H.R. 1 (as passed the House)
<p>fees (if the fee is authorized by another law) or raise fees for services provided by the IRS to supplement appropriations made available to the IRS. The fees must be based on the costs of providing the specific services (to the persons paying the fees), and the Secretary must report quarterly to the Congress on the collection of such fees and how they are spent.</p>		<p>fees collected are only available to the IRS if authority is provided in advance in an appropriations Act.</p>	

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